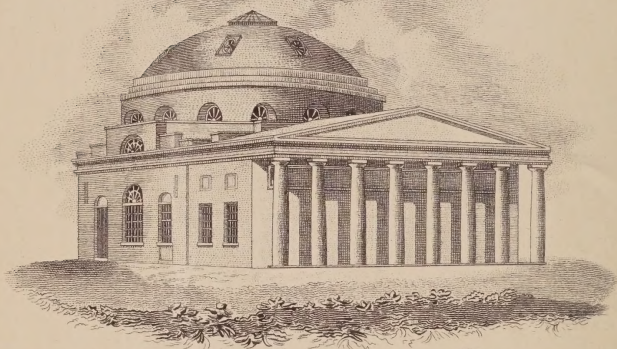
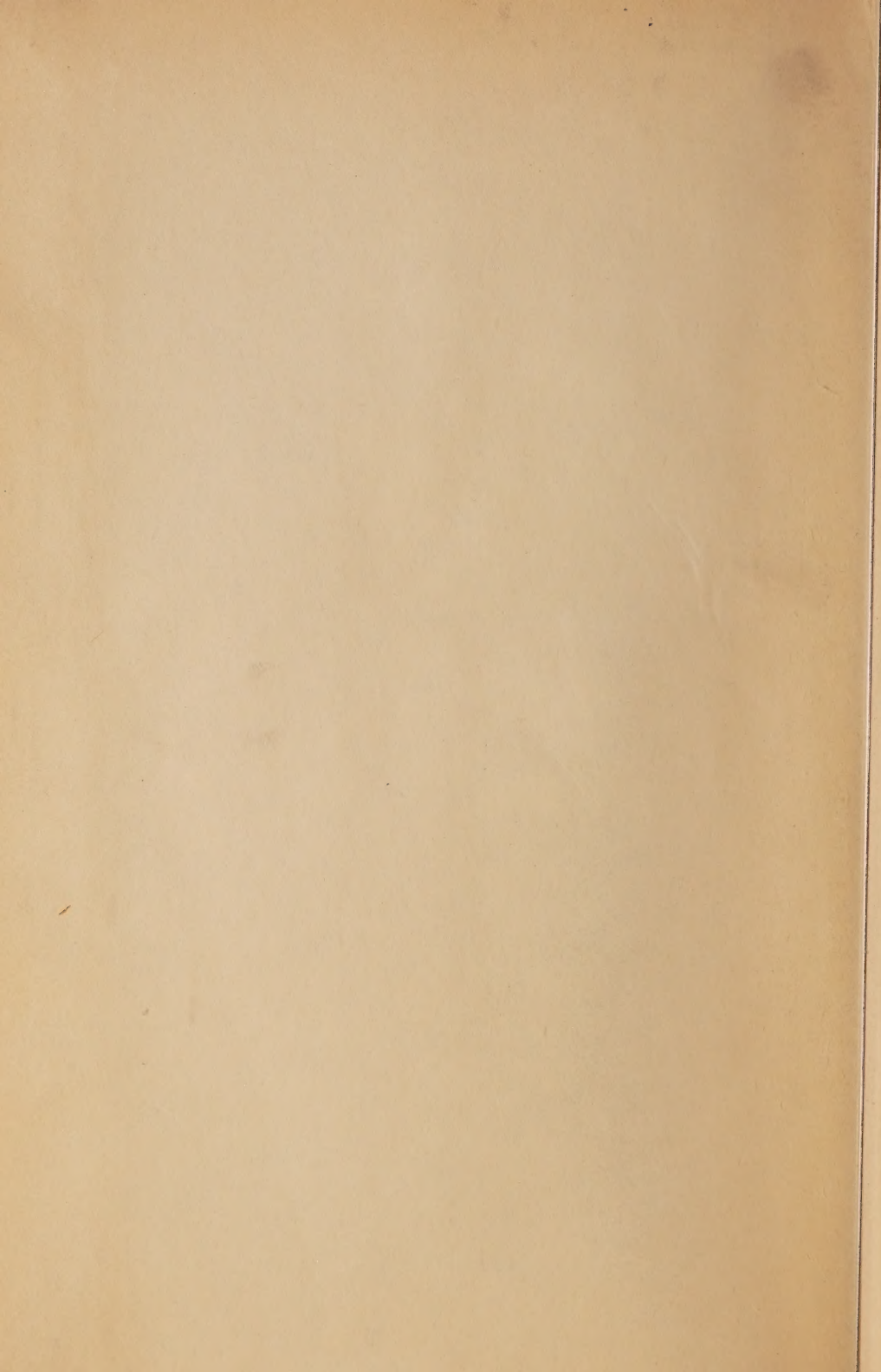


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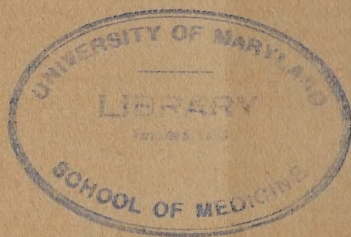


THE JOURNAL
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ALUMNI ASSOCIATION
OF THE
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BALTIMORE.

Vol. I

No. 1

APRIL, 1898



7223

The Pasteur Department of the Baltimore City Hospital.

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—PROF. THOS. S. LATIMER, M. D.

Chief of the Laboratory.—PROF. N. G. KEIRLE, A. M., M. D.

Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. B., M. D.

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REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Personal Notes.

DR. J. W. LEITCH, '96, who is practicing at Huntingtown, Calvert Co., Md., visited the College February 25.

DR. FRANK W. GERMON, '73, has recently been appointed by the Governor to be one of the Coroners for Baltimore City.

DR. DALLAS BERNHARDT, '85, is a member of the Legislature. He is not practicing, but living at Orbesonia, Pa., on a large estate recently inherited.

DR. EUGENE G. CARPENTER, '84, for five years was first assistant physician to the Cleveland, Ohio, State Hospital for the Insane. He then put in two and a half years in Europe studying neurology. He now has a flourishing practice in Cleveland, and is recognized as one of the leading neurologists of the State.

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Personal Notes.

DR. H. J. ARNOLD, '90, is doing well at Columbus, Nebraska. His practice consists mainly of general surgery.

DR. L. F. ANKRIM, '86, at one time Assistant Demonstrator of Anatomy at the College, is located at 5201 Penn ave., Pittsburgh, Pa.

DR. JOHN H. CARMAN, '86, has been one of the attending physicians to Muhlenberg Hospital, Plainfield, N. J., for the past eight years.

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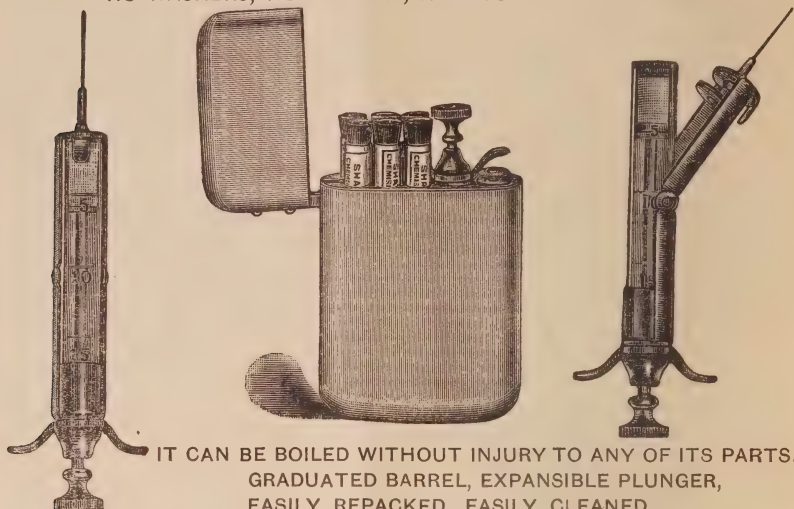
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ADDRESS DELIVERED AT THE SEMI-ANNUAL MEETING

By DR. A. B. ARNOLD, '48.

Gentlemen:—I offer my grateful acknowledgment for the honor conferred upon me to address this meeting, and to express the pleasure this occasion affords me to greet in the spirit of cordial fellowship the Alumni of the College of Physicians and Surgeons of Baltimore. I desire to convey the sentiments of my lasting gratitude to that school of medicine, and to the Medical and Chirurgical Faculty of Maryland, in whose library hall we are assembled this evening. In looking around me I miss the presence of many of my colleagues, who have departed from us, whose friendship I had greatly valued, whose accomplishments I admired and who in their lives were ornaments of their profession. It is a highly commendable custom for the alumni of schools of learning and of science to meet at appointed times to shake hands, to talk over one of the most interesting periods of their early careers, and to manifest the feelings of pride and honor in the standing and prosperity of their Alma Mater.

I hope you will pardon me, gentlemen, as being perhaps the oldest member of our Alumni, if I shall indulge for a moment in offering a few remarks on subjects that may not be improperly discussed on an

occasion like the present. Although they are not new, yet some useful lessons may be drawn from them when presented from a certain point of view. In my young days when I began to practice medicine we were still shedding blood in inflammations and acute fevers. I had then the boldness, or rather the presumption, to express at the meetings of our local medical associations my scepticism with regard to the benefit of bleeding in these diseases, and got the name of nihilist for my trouble. I remember that in a case of croupous pneumonia in a young patient I called in one of my senior colleagues for consultation, who at once recommended profuse venesection. Unfortunately I consented. Our patient died on the fourth day of the disease. Very innocently I asked the doctor's opinion in reference to the cause of this early death, and with a somewhat pitying look at my naiveté, he told me that I did not bleed enough. I then ventured to suggest that the man died to all appearance of heart failure. Not at all, he replied—on the contrary, the patient's circulation was too strong. The strange thing about venesection is the fact that for centuries it had the sanction of experience among surgeons and medical men. A profitable lesson may be learned from the disgrace of the lancet, that although tradition is venerable it must ultimately recede before better knowledge. For a long time afterward the lancet was still upheld by "practical men." Of course sensible people never undervalue experience, but it should not be forgotten that you cannot prescribe for the simplest ailment in a rational way that does not involve a theory. We are not satisfied in ascertaining the mere effects of empirical remedies. Therapeutical science is constantly at work to study out the manner of their action, and the information thus acquired enables us to extend their application to a number of morbid conditions. Still therapeutics has always been the most backward of all the branches of medical science. This could hardly be otherwise, for pathology and diagnosis are so far in advance as to outstrip our means of cure; and for all that, the therapeutics of the present day has made great strides, and treatment is now carried on from a more rational basis than formerly. We no longer wage war against disease by violent measures, for we know that in innumerable

cases the enemy cannot be purged out, nor vomited away, nor sweated off. We begin to have a decent regard for the resources of nature and, like the obstetrician, we assist her by all our available means to a safe delivery. Who can deny the incalculable benefit which this new departure confers on patients! But above all, therapeutics has now entered upon a new era of conquest, especially through the method of what is called the sero-organic therapeutics. In contradistinction to drawing our remedial agents from the inorganic world, we avail ourselves of the antagonistic plasmic power of organic elements. I refer to Behring's anti-toxin treatment in diphtheria, which has been followed by sufficient success to indicate the direction where promising remedial substances can be sought for. I would also allude, in confirmation of the same fact, to the thyroidal treatment which has been successfully employed in myxœdema, cretinism, and for the reduction of the bodily weight. All this shows what purely scientific research is able to accomplish for the advancement of the healing art. The circumstance is especially noteworthy that in the mentioned examples they were the result of logical conclusions, and enriched therapeutics by valuable remedies which were not derived from the experience of unprofessional people, like ergot and cinchona bark.

Allow me to advert to the enormous increase of medical literature in these days. The wonder is that generally it is of good quality. In fact, hasty speculations and an exuberance of hypotheses are no longer relished. Etiology, which is the most obscure branch of medicine, has in relatively recent times made an extraordinary advance through the agency of bacteriology, which came upon us like a revelation, although the older pathologists had an inkling of it. A vast amount of false pathology has thus been swept away by this new and invaluable accession to our knowledge. I am tempted in this connection to allude to a lengthy chapter of the old editions of Reynolds' Practice of Medicine, where pulmonary tuberculosis is attributed to indigestion.

I desire to draw your particular attention to the very unsatisfactory procedure adopted in our law courts when medical expert testimony

is called for. Each party in the case has the privilege of employing experts, whose opinion is a foregone conclusion. Direct contradictions under these circumstances must inevitably ensue, to the great mortification of the profession. Judge and jury cannot help forming a damaging opinion of this clashing of testimony, and form an unfavorable estimation of the trustworthiness of medical and chemical science. The French courts have overcome the difficulty by resorting to the appointment of a commission of medical experts, whose duty it is to report the result of their professional inquiry in the case to the court. The adoption of such a provision by the official authorities in our courts would be highly desirable, and may perhaps be brought about by a proper agitation of the matter.

There is perhaps no subject of greater importance to the medical profession in its relation to jurisprudence than the question of moral responsibility under the influence of intoxicating drinks. Many able contributions of the medical press on this subject have appeared from time to time, but thus far no unanimity has been reached. The matter in dispute is much complicated by theological considerations. Medical men, however, are agreed that a morbid condition of the brain is effected by intoxication, manifest in a disordered action of its mental functions. The latter is also recognized by every unprofessional person. It is a well known fact that a large number of habitual inebriates are affected by permanent mental debasement, which is chiefly displayed by a low moral tone. Alienists are disposed to class the recurrence of an irresistible desire for intoxicating drink (dipsomania) with the irregular attacks of epilepsy. This condition bears much resemblance to the irresistible inclination to incendiarism to which young boys and girls are liable at a certain period of their lives. From a strictly medical point of view it must be admitted that the state of intoxication is a disease, or rather a disorder; but it cannot be denied that habitual drunkenness is a vice which, like all vices, shows weakness of the moral will-power.

The objections which now begin to find expression against the enormous increase of public dispensaries, and the money spent on them, are certainly well founded. The appropriations intended for the

indigent poor are very frequently squandered on a class of persons who have no justifiable claims on them. That these dispensaries encourage pauperism is evident. Dr. Shrader of New York, who made especial inquiries about the abuse of free dispensaries, reports a large number of cases where women draped in furs and sporting jewelry thronged these places for advice and drugs. Country people coming in their wagons frequently receive the same accommodations. Dr. Shrader does not hesitate to blame medical schools for sharing in this abuse, although the plea may be set up that these institutions wish to utilize the clinical material which these free dispensaries furnish. There is some humor in the Doctor's remarks, when reminding young graduates just entering into practice and waiting for patients, that they are deprived of the legitimate income at a time they might need it the most if people who can well afford to pay a moderate fee resort to the free gifts of these dispensaries.

In conclusion, permit me to advise the young alumnus to keep himself in touch with the progress of his art and its literature. He will in this way not only equip himself for the better discharge of his professional duties, but will also enjoy an intellectual pleasure and the culture of a refined taste. Science never grows old. The unknown is infinite, but every research into the secrets of nature lessens that infinitude. The keen love of inquiry also exerts a moral influence by fostering a love for the truth. Every addition to our knowledge gives us a deeper insight into the workshop of nature and increases our means of ministering to the wants of man. It is this which makes medicine a divine art.

A SYNOPSIS OF THE WORKINGS OF THE PASTEUR DEPARTMENT.

BY DR. JOHN RUHRÄH, '94.

Inasmuch as no statement of the working methods of the Pasteur Department of the College has ever been made in the medical papers, it is deemed fitting that the first number of this Journal should contain a brief account of its origin and the methods employed daily.

Subsequently we hope to be able to correct many erroneous impressions and ideas that are held both by the laity and many otherwise well-informed members of the profession.

The origin of the department is to be found in the careful and painstaking work of Dr. Keirle, who for several years past has been experimenting with the virus of rabies and observing the clinical features of the disease both in animals and in man. Unfortunately lack of funds prevented the College from undertaking the work of the preventive inoculation after Pasteur's methods. About one year ago, however, a number of boys were bitten by a rabid dog, and through the good offices of the *Sun* the necessary funds were raised to send the victims to the Pasteur Institute in New York. The amount raised was in excess of the immediate needs, and the balance was turned over by the *Sun* to the College to start an institute in Baltimore. In order that the methods used might be identical with those in vogue in the mother institute in Paris, the writer was sent there to study the treatment.

On the fourteenth of April, 1897, the necessary preparations had been completed. Singularly enough a patient from southern Maryland applied for treatment the same day. Since that time some thirty-five patients have been treated and the results have been uniformly satisfactory.

The daily routine of the department consists in removing, under the strictest aseptic precautions, the spinal cord from a rabbit which has died of rabies. This is suspended in a sterilized bottle of special shape, over a layer of caustic potash, which acts as a drying agent. These bottles are then placed in a dark room, which is kept at a uniform temperature of 23° C.

A small portion of the floor of the fourth ventricle of the dead rabbit is used to inoculate a rabbit each day in order to secure a cord for each day in the year. To guard against losing a day by the accidental death of the rabbit, two rabbits are inoculated daily. The inoculations are made by removing a small button of bone from the skull of a rabbit by means of a trephine and injecting subdurally an emulsion of the brain substance above mentioned; this brain sub-

stance, containing the rabic virus, having previously been rubbed up into a smooth emulsion, using sterilized water as a diluent. The virus used is what is known as a *fixed* virus, and the incubation period of the disease when this is used is always seven days. The death of the rabbit occurs on or about the twelfth day. These laboratory manipulations require unusual care and vigilance to obtain perfectly uniform results, and are under the direct supervision of Prof. Keirle, the chief of the laboratory. They are carried out with the assistance of Mr. N. G. Keirle, Jr.

The cords which are placed in the dark room are attenuated by the drying process to known degrees of virulence, the material used for inoculation being made directly from them by rubbing up into a smooth emulsion one-half a linear centimetre of an average sized cord with three cubic centimetres of sterilized water. Of the weaker cords, *i. e.* those which have dried for from seven to fourteen days, three cubic centimetres of the emulsion are used for a dose. Of the stronger cords, *i. e.* those which have dried from three to six days only, two cubic centimetres of the emulsion are used. The cords of the first and second day are never used in the treatment.

These injections are given hypodermatically, the site of the inoculation being the subcutaneous tissue of the abdomen. The treatment is carried on from twenty-one to twenty-three days, the following being a specimen of the record of the quantity and the age cord used:

1st day, 2 injections, 3cc. 14-18 day cord.			
2nd	"	2	" 3cc. 12-11 " "
3rd	"	2	" 3cc. 10-9 " "
4th	"	2	" 3cc. 7-8 " "
5th	"	2	" 2cc. 6-6 " "
6th	"	1	" 2cc. 5 " "
7th	"	1	" 2cc. 5 " "
8th	"	1	" 2cc. 4 " "
9th	"	1	" 1½cc. 3 " "
10th	"	1	" 2cc. 5 " "
11th	"	1	" 2cc. 4 " "
12th	"	1	" 2cc. 3 " "
13th	"	1	" 2cc. 5 " "
14th	"	1	" 2cc. 4 " "
15th	"	1	" 2cc. 3 " "
16th	"	1	" 2cc. 5 " "
17th	"	1	" 2cc. 4 " "
18th	"	1	" 2cc. 3 " "
19th	"	1	" 2cc. 5 " "
20th	"	1	" 2cc. 4 " "
21st	"	1	" 2cc. 3 " "

In order to guard against the introduction of any pus-producing germs a culture is made from each piece of cord before it is used, by cutting of a small portion into a tube of sterilized bouillon. The best test of the efficiency and harmlessness of the treatment is the results. In all the cases treated up to date there has not been any abscess formation nor bad effects from the injections. The results as to its preventive action in the disease in question will be dealt with more fully in the detailed report at the end of the first year. Suffice it to say that over two-thirds of the cases treated were bitten by dogs proved to be mad by laboratory experiments, and in all cases by the clinical history of the dog, and so far the results have been, as above stated, uniformly satisfactory.

EXAMINATION OF THE PERSON.

MEDICO-LEGAL STATUS OF THE GONOCOCCUS.

DR. N. G. KEIRLE,

Medical Examiner for Baltimore City.

Can the body of an accused person be examined without consent? Suppose an individual is accused of rape and it is alleged that he communicated venereal disease: can his person (genitals) be examined without consent? Suppose a woman is accused of killing her newborn child: can she be examined, without consent, to ascertain recent delivery? There is no law nor statute, so far as the writer knows, in the United States or Great Britain that compels the examination of the person. In France a Court of Instruction is empowered to issue such order. Prof. Brouardel of Paris examined the body of Pranzini, afterwards beheaded, who, after cohabitation with the mistress of the house, killed her and two female servants by cutting their throats. The body of Pranzini exhibited scratches, which he asserted were made by himself. In explanation of the manner, he scratched himself from below upwards. The skin, with a hand-glass magnifier, was shown to have been abraded by a scratching downwards. A curious feature of this examination was the measurement of the penis of the accused. If the pars pudenda be examined without consent the examiner is

liable for indecent assault. Submission to examination without remonstrance is not evidence of consent, which should be obtained in the presence of witnesses. That the accused is in custody of the law does not waive this individual personal right. "If a magistrate or other authority orders a medical practitioner to examine a woman without consent, and the order is carried out, both parties are liable to prosecution." (Vid. Prof. J. Dixon Mann, M. D., Forensic Medicine, p. 103.)

Is the presence of the gonococcus of Neisser sufficient to prove, medico-legally, the existence of venereal infection?

It is evident that this question is of momentous import. Affirmatively it will not be accepted by the courts until all reasonable doubt shall have been removed. "In the present condition of bacteriology we are not in a position to say that the presence or absence of gonococci would justify a statement on oath either for or against specific infection." "The société de Médecine Légale de France accepted these views." (Vid. J. Dixon Mann, M. D., Forensic Medicine, 1893, p. 99.)

"The gonococcus of Neisser in the urethral or vaginal discharges would go far to prove the existence of gonorrheal infection." (Vid. System of Legal Medicine, by Allan McLane Hamilton, M. D.; article by F. R. Sturgis, M. D., vol. 2nd, p. 505, 1895.)

"It (the role of the gonococcus) seems hardly a question for legal medicine to decide. It had better be referred to the men who are thoroughly familiar with all its practical phases, and we shall abide by the opinion of the majority." Medical Jurisprudence and Toxicology, Witthaus and Becker, article by Edgar and Johnston, vol. 2nd, p. 440 et seq., 1894.

The only opinion devoid of vagueness is that of J. Dixon Mann. That the gonococcus "would go *far* to prove" is not enough. It must be proved *all* the way. "The opinion of the majority" is not enough so long as a respectable minority persists in differing. There must be a consensus of reputable opinion. The dissent must be restricted to cranks who, educated or uneducated, are incapable of forming a sensible opinion because their "judgment has been taken away."

The etiological evidence of the gonococcus consists of three divisions:

1st. Its morphology and seat.

2nd. Its staining and cultural peculiarities.

3rd. The production of infection in the human animal, by pure culture, experimentally.

The presence of this peculiar coccus in cells may suffice for the expression of a laboratory opinion, which involves only a mistake. No bacteriologist, under oath in a court of justice, giving evidence in a case involving most serious consequences, would base his testimony on the unsupported morphology. Suppose that both the 1st and 2nd requirements are fulfilled? In order to answer this query the writer consulted three physicians especially skilled in bacteriology. One asserted that under the above conditions he would affirm the existence of venereal infection, directly or indirectly. Two asserted that they would *not* so testify. To one of these two physicians the coexistence of the 3rd requirement was not submitted. The other of these two physicians, who suggested the 3rd requisite, stated that though the organism fulfilled all three conditions, he would *not* under oath testify his belief in the absolute certainty of its etiological demonstration; in other words, he would not regard venereal infection as having been proved beyond all possible doubt, all "reasonable" doubt.

The morphology of a single spermatozoon would suffice to demonstrate with absolute certainty that an individual, *e. g.* a female, had directly or indirectly, immediately or remotely, come into contact with the semen of the male. No one familiar with its morphology could possibly have any doubt. On the contrary, no one, however familiar with the morphology of the gonococcus, could from the presence of one organism having this morphology assert the existence of venereal infection. As regards the 2nd requirement, the future and its accumulated investigations may reveal some organism having the same staining and cultural properties. For a long time the failure to decolorize with acid was supposed to be a distinctive property of the tubercle bacillus. Against the 3rd requirement (from the nature of the case, in itself very difficult of attainment) it may be alleged that the normal habitat of the gonococcus may be found to

be in the body; that further research may show that it is, normally, present somewhere in the genito-urinary tract, that it is not always virulent, that the conditions under which it acquires virulence may not always have venery as a *sine qua non*. Many of these assertions are of course mere hypotheses and therefore of little value; but the fact remains that with skill and experience doctors differ regarding the subject under consideration. "When doctors disagree, who shall decide?" Why, the judge or jury. In a criminal case the latter will decide that this difference of opinion among equally skilled experts raises and constitutes a reasonable doubt. In a civil case the judge might instruct the jury to disregard testimony relative to the causal relation of the gonococcus. Let the following data set forth a hypothetical case. A woman as far above suspicion as human frailty admits, with a genito-urinary tract clean to gross inspection, but when the platinum loop is rubbed over the parts and then over the culture medium a growth results having the morphology and seat of the gonococcus together with its cultural and staining peculiarities; additionally, the pure culture introduced experimentally into the genito-urinary tract of the human being produces a purulent inflammation also exhibiting the gonococcus. Suppose the above case be submitted to what in some States is termed a struck jury, *i. e.* a jury composed of those who have a knowledge of the subject under consideration. The result would be failure to agree upon a verdict. If the evidence included only the 1st and 2nd requirements the most pessimistic would bring in the old Scotch verdict—"not proven."

SOME INTERESTING CASES OF DISEASES OF THE STOMACH.

BY DR. JULIUS FRIEDENWALD, '90.

REPORT No. 1.

DILATATION OF THE STOMACH. GASTRO-ENTEROSTOMY.

The first case is G. L., who entered the City Hospital, January 6, 1896. He was fifty years of age, was a Swiss and a beer brewer. In 1887, after drinking cold beer the first signs of gastric disorder

made their appearance. He began to vomit frequently after eating; suffered with heartburn, sour eructations and pain in his stomach. The attacks would come on periodically; in the intervals he felt perfectly well, though he always had to be careful with his diet, for any indiscretion was followed by an attack. He had recently been drinking much beer, fifty to sixty glasses a day, and the attacks were very frequent. The patient now complains of frequent vomiting, belching, often vomits food eaten the day before, has eructations of sulphureted hydrogen, and suffers with constant pain in his stomach. The patient has lost much weight (45 pounds). Urine normal, though scanty. The abdomen is flabby; the stomach reaches (by succussion) three fingers' breadth below the umbilicus; no resistance can be made out. The stomach on inflation was found to reach three fingers' breadth below the umbilicus. On emptying the stomach of its contents sixteen hours after partaking of food a large quantity of much fermented contents was obtained (200 cc.). It contained raisins which had been eaten the day before. The gastric contents removed either in the morning before the ingestion of any food or after an ordinary Ewald test breakfast always showed the same results, namely, large quantities with a high total acidity (100), free hydrochloric acid (.15 to .25 per cent) and sarcinæ in abundance. The stomach was daily washed and the patient carefully dieted. He began to improve, gained twenty pounds in weight, and left the hospital, July 1, 1896.

On August 12, 1896, he again returned, much emaciated; he now complained of frequent attacks of vomiting, dizziness and abdominal pains. His gastric contents were examined daily and always showed results similar to those already described. Lavage was again practiced daily, but without favorable results. We then determined to have an operation performed on our patient.

October 28, 1896, Dr. John W. Chambers did a gastroenterostomy, using Murphy's button. The patient was fed per rectum with nutrient enemata for five days; he did well and had no fever and but little pain. On the fourth of November the patient was suddenly attacked with great abdominal pain; his extremities became cold and his body was covered with cold sweat; his pulse became rapid; there

was no fever; the abdomen became distended and slightly tympanitic, and he died on the next morning.

The abdomen was opened after death and the stomach and a portion of the duodenum removed. It was discovered that the button had ulcerated through the anterior portion of the stomach, while the adhesions were firm behind and at the sides. Acute perforating peritonitis was the cause of the death. The stomach was remarkable in many ways:

1. It was enormously dilated, holding 2500 cc. of fluid.

2. There was an entire absence of all indications of former ulceration at the pylorus. The pylorus was contracted by a ring of fibrous tissue in the peritoneal layer.

3. The case was also interesting from the fact that the Murphy button slipped from its position before adhesions between the stomach and intestines had become sufficiently firm.

310 N. Eutaw St.

A CASE OF PUERPERAL SEPTICEMIA TREATED WITH ANTISTREPTOCOCCUS SERUM.

BY DR. CHAS. EMIL BRACK, '95.

Mrs. K., 24 years of age, vigorous, hard-working German woman; multipara. Had always enjoyed good health. Two years ago she was delivered of a dead child by a midwife, and treated for several months subsequently for endometritis.

Delivered on December 11th by high forceps after a rather tedious labor of 24 hours. Os had dilated fully, with head remaining persistently at the brim. Male type of pelvis, deep symphysis and narrow outlet. Conjugata vera $3\frac{3}{4}$ inches.

In consultation with Dr. Wm. R. Steinmetz and Dr. W. E. Miller, forceps were decided upon and delivery effected without very much trouble. Strictest antiseptic precautions were observed.

Child was asphyxiated (asphyxia pallida); no heart sounds could be detected. Efforts at resuscitation were made for one and a half hours by methods of Schultz, Marshall Hall, Sylvester, and alternate

hot and cold baths. Mucus was removed from trachea by means of a catheter, and the lungs inflated by mouth to mouth inhalation. After about one hour's work the heart was found to beat, and later the child gave a gasp, which was repeated at shorter intervals until normal respiration occurred. Child died on the day following delivery.

In the meantime the placenta had been delivered by Credé's method and was pronounced entire.

Birth of placenta was followed by severe hemorrhage, which was finally controlled by copious hot intrauterine douches and hypodermatic injections of ergotole. Condition of patient after recovery from chloroform was good; temp. 100, pulse 90, resp. 28. There was no further bleeding, lochia were normal; during the following eight days, the temperature morning and evening never exceeded 99.5, pulse 84 to 88, never above 90; respirations 26 to 28.

On the ninth day patient developed a chill which was followed by temperature of 102, pulse 120. Breasts had been dried by tight bandaging and belladonna inunctions; they were at this time in good condition.

Lochia were scant and had marked disagreeable odor. An intra-uterine douche of bichloride 1-5000 followed by hot water was given and a saline cathartic. On the tenth day the condition remained the same. Uterus was explored and a mass of retained placenta removed; this was decomposed and of marked odor. Uterus was thoroughly curetted and washed out with bichloride and hot water.

Douches of hot water and creolin were given twice a day, but neither fever nor pulse rate was influenced by the treatment.

Patient had nausea, loss of appetite, coated tongue, fetid breath, skin was cold and clammy, constipation, and became very weak. Whiskey, iron, strychnia and salines were administered.

Temperature fluctuated between 101 and 102.5; pulse 120 to 130.

Microscopic examination of uterine discharges showed streptococci in abundance.

On the 24th of December 10 cc. of antistreptococcus serum (Pasteur) were introduced into the buttock, and on the following day an additional 5 cc.

A diffuse rash appeared within 12 hours of the first injection; it was of a pale red; the affected portions of the skin appeared raised, the borders were irregular in outline but well defined. There was no œdema, no thickening, no itching or burning; the eruption appeared over the external genitalia, inner portion of the thighs and over buttocks. Patient complained of severe pain in hip joint, and the flexor muscles of the thigh appeared strongly contracted. A rise of temperature to 103 followed the injection, while the pulse became 84 to 88.

There was no jaundice, no tenderness except in the left hip.

The face was flushed, tongue became clear, patient became much brighter; there was a marked improvement of her general condition.

On the 26th 15 cc. of serum were injected. Temperature rose to 104 and 105, pulse became 70 to 76.

The eruption spread to the lower border of the scapula and down over thighs.

For a week the temperature remained high, with the pulse rate accompanying of 70 to 76. There was a marked absence of the usual phenomena of high temperature. Patient was bright, talked pleasantly, and complained of nothing but the pain in the hip, which was not very annoying and gradually disappeared. The eruption gradually faded and disappeared almost entirely at the end of the week.

On the 25th patient had a severe attack of pain on right side over scapula, shoulder and infraclavicular region, which was relieved on the following day.

On the 27th a troublesome cough made its appearance; expectoration free, of a thick purulent sputum which, upon examination, showed large numbers of streptococci. Coarse, bubbling rales were heard over left chest, there was no dulness on percussion, no bronchophony; there was no pain.

Heart sounds were clear and of normal relative intensity. Urine of low specific gravity, pale, contained a few granular and hyaline casts.

At the end of one week temperature began to subside to 102 and 102.5, but the pulse remained the same.

Occasional intrauterine douches of creolin and hot water were given; there was still some discharge, with occasional shreds of decomposed tissue and slight amount of bleeding. The uterus was enlarged, soft, and readily admitted a large glass douche-tube.

An examination of the blood showed marked leucocytosis; no malarial organisms.

Cough persisted and rales were heard on both sides of chest. Patient was given turpentine, strychnia, digitalis and whiskey.

On the 7th of January 30 cc. P. D. & Co.'s antistreptococcus serum were injected. This was again followed by a rise of temperature to 102 and 103; pulse became 80 and 84.

A rash, similar in character to the first, appeared on the left leg and extended from the lower border of the first eruption to the lower margin of the knee. Its appearance was associated with severe pain and swelling of the knee joint. There was no fluctuation in the joint, no œdema of the skin.

Patient's condition at this time very fair. No marked emaciation; appetite fair, tongue clear, bowels normal. No disturbance of sensation, patellar reflexes feeble but present. There was still some cough.

There was no marked improvement for the next two weeks. Temperature fluctuated between 100.5 and 103; pulse about 90. Patient was allowed and encouraged to sit up in bed, and at the end of this period sat in chair, but could not remain up for more than 10 or 15 minutes.

On the 25th of January 20 cc. P. D. & Co.'s antistreptococcus serum, two weeks old, were injected.

An eruption again appeared upon the lower left leg from the knee to ankle; it was much paler than the previous eruptions; there was some pain in the calf of the leg. It lasted about three days and faded away.

The temperature subsided gradually to normal on the fourth day, while the pulse rate increased to 120 and remained so for the following ten days. The cough disappeared; patient sat up for three or four hours at a time in a few days, and from this time on made an uninterrupted recovery.

In addition to the serum injections the therapy included such stimulants as port wine, whiskey in egg-nogg and milk-punches, champagne, strychnia, digitalis. Iron was given in the form of the pepto-manganate. Antifebrile treatment of quinine, guaiacol carbonate, cold pack, but seemed to have but little if any influence upon the fever. For the cough, inhalations of thymol, eucalyptol and creasote were used; codeine, acentanilid internally.

The case was undoubtedly a streptococcus infection. The injections of the serum were followed in each instance by certain very marked phenomena, and the patient's condition improved after each injection.

The most marked improvement followed the fourth and last injection, and the associated phenomena, though alike in character, were of a milder nature than after the previous treatment.

The serum used for the first injections was the product of the Pasteur Institute in Chicago and its age not known.

For the third injection Parke, Davis & Co. serum was used and about a year old.

The last serum used was obtained from Parke, Davis & Co. and quite fresh, being but two weeks old.

A CASE OF HEMIPLEGIA WITH APHASIA (VISUO-MOTOR).

REPORTED BY H. WESTPHAL FROM THE SERVICE OF DR. GEO. J. PRESTON.

P. Q., native of Ireland, æt. 65 years. Came to this country in 1862, contracted variola on board ship. Indefinite history of syphilis (bubo, falling out of hair, sore throat; later on bullous eruption on different parts of body). Had rheumatism in shoulders and ankles. Gives alcoholic history, uses tobacco freely. Married 20 years, wife healthy, three healthy living children, one died with symptoms of jaundice.

Well up to December 2nd, '97. While out walking slipped and fell, striking right side of head. Felt dizzy, but after short while was able to walk home. By the time he retired felt fairly well. His

sleep was undisturbed. On rising next morning found that he was "all wrong." His mind was confused, his right arm and leg felt numb and their use was much interfered with. Walked to hospital at noon with great difficulty. He had very little control over right leg and frequently collided with people. Felt giddy and had pain in head.

On admission right hemiplegia and right hemianopsia were observed. Next morning complained "that he did not understand meaning of words he read." Interference with deglutition was marked for four days. Had moderately severe pains in right arm, starting in neck and shooting down towards wrist. No pain in leg.

STATUS PRAESENS. Feb. 16. Fairly well nourished. Indurated gland in right inguinal region, skin over which showed several small cicatrices, otherwise no glandular enlargements or other signs of syphilis. No difference in measurements of extremities. *Lungs* normal. *Vascular system, heart*, sounds rather faint, accentuation of aortic second sound; arteries, no atheroma. *Liver*, one inch below costal arch. *Spleen*, not palpable. *Genito-urinary system* normal.

MOTOR AND MUSCULAR. *Hemiplegia of right side*, arm affected most, leg affected less, face affected least. *Face*, left angle of mouth drawn up, otherwise not much distortion of features. Tongue on protruding deviates to the paralyzed side and shows fibrillary tremor. *Right arm*, complete paralysis; spastic condition. Forearm flexed on arm, fingers on palm. *Right leg*, incomplete paralysis, spasticity not quite so marked, has some use of it, walks with cane, swinging leg around, toes scraping floor. *Left side*, power somewhat diminished. *Sphincters* normal. *Reflexes*, superficial, slightly increased; deep, enormously exaggerated; ankle clonus.

SENSORY. *Cutaneous*, no anæsthesia. Tactile sense somewhat diminished, fails to appreciate the contact of the two points of the æsthesiometer on lips at distance of 5 mm., tip of nose at distance of 11 mm., forearm at distance of 15 mm., neck at distance of 45 mm., leg at distance of 150 mm. Cannot well locate spots touched on skin. Temperature sense and pain sense good.

SPECIAL SENSES. *Eyes*, extrinsic muscles normal, no nystagmus. Pupillary right reflex somewhat sluggish. No hemianopsia. Fun-

dus oculi normal on ophthalmoscopic examination. *Hearing*, hears watch at distance of two feet on both sides. *Smell* and *taste* normal. *Speech*, thick on account of partial paralysis of tongue, but he pronounces labial consonants and vowels without trouble. *Mentality*, patient is somewhat dull, has pronounced loss of memory, but is fairly cheerful.

Aphasia. Examination shows that patient repeats words or sentences without trouble, readily comprehends gestures and names, and appreciates use of objects.

Alexia. He can read some short, frequently used words, especially when printed in large italics, but fails absolutely in reading even very short sentences. After he has, with help of examiner, laboriously spelled out the component words of a passage, is unable to repeat it, nor does what he has spelled out convey the slightest meaning to his mind. When a simple word is written in large letters and his hand guided over them as he tries to spell he does better.

Aphemia. He has trouble in expressing his ideas properly at times; he will use an entirely wrong word, being perfectly conscious that he has not employed the word he wanted to use. This aphemic condition, however, is not well marked except in connection with figures. He almost invariably gets the wrong number. For instance, asked the number of his children, will say eight, at the same time telling you that it is not what he meant to say. Five fingers being held up to him he gets a wrong number, but is able to count correctly by touching each one as he counts 1, 2, 3, 4, 5. Again, here, as in reading, his tactile sense comes to his aid.

Agraphia. Patient is unable to write the simplest words or even letters.

Out of 67 cases of hemiplegia treated at the City Hospital, 37 were right hemiplegias, complicated with 9 cases of aphasia. 1 case of temporary aphasia occurred in a left hemiplegia. Seguin * compiled statistics of 260 cases, being divided thus: hemiplegia with aphasia—right, 243; left, 17. As to question of location of lesion in the left ant. lobe, he shows 514 post-mortems for and 31 against.†

* Quarterly Journal Psycholog. Med., 1868, ii, 74-119.

† Loc. cit.

In connection with this case, the one reported by Bastian (*Brit. Med. Journal*, 1896, ii, 1570 and 1712) is of interest, chiefly on account of the post-mortem examination. The aphasia was visuo-auditory. The post-mortem examination showed: (1) complete atrophy of convolutions supplied by the left middle cerebral artery. Atrophy extending inwards, so as to lay open lateral ventricles. (2) Whole of this region was occupied by large pseudo-cyst. Complete disappearance of supramarginal gyrus, angular gyrus, posterior $\frac{2}{3}$ of upper temporal convolutions.

A CASE OF ACUTE LYMPHATIC LEUKÆMIA.

By DR. MELVIN S. ROSENTHAL, '91, AND DR. STANDISH McCLEARY, '90.

The almost unanimous opinion regarding leukæmia as a chronic disease tending to a fatal termination in from one to three years makes the following case one of rare interest:

On July 9, '97, H. T., a youth of 19 years, presented himself at the Hebrew Hospital for treatment of an effusion in the right side of the chest. Family history good. With the exception of a "fever" several years ago the patient has always been in robust health. For four years has been living in Baltimore, previous life spent in Russia. Since his sixteenth year has been working at blacksmithing. Past four weeks has complained of pains in limbs, lassitude, headache, muscular weakness, pain in left side of chest, increased by a slight persistent cough. Has had two attacks of nasal hemorrhage.

Present condition.—Body fairly well nourished, pallor marked, mucous membranes anæmic, great dyspnœa, unable to make the slightest exertion. Pain in left side of chest. On physical examination evidences of profuse pleural effusion on left side, which was confirmed by exploratory paracentesis. Character of fluid withdrawn was sanguineous. Heart displaced to right side, feeble and rapid. No organic lesion. Slight enlargement of the liver. Spleen palpable. Temperature normal. Urine and sputum negative. Blood exami-

nation, July 12, revealed a pronounced anæmia, with a number of nucleated red cells. Otherwise no change in the cellular elements. Hæmoglobin, 40 per cent. About 8 fl. ounces were withdrawn from the chest to relieve the dyspnœa. The character of the fluid was dark and bloody. Patient put on tonic treatment, with increasing dose of arsenic. The operation of paracentesis to relieve the breathing was repeated a number of times. An examination of the fluid showed it to be largely composed of blood. Between the 12th and 16th of July the blood was examined a number of times without any changes being noted in the cells.

The gradual increase in the size of the spleen with corresponding amount of dyspnœa, enlargement of the cervical, axillary and inguinal glands, no apparent change in the patient's condition in spite of careful administration of iron and arsenic, prompted an examination of the blood 15 days after the last administration. On this occasion the existence of lymphatic leukæmia was unquestionable.

The count of the red cells made on August 1 with the Thoma Zeiss apparatus gave 2,250,000 per cmm. The whites numbered 500,000, giving a ratio of nearly one white to four red cells, a much higher proportion than usually observed in lymphatic leukæmia.

Hæmoglobin showed 35 per cent by Fleischl test. Fixed specimens of the blood were stained by Ehrlich's triple stain; also by Delafield's hæmatoxylon followed by $\frac{1}{2}$ per cent eosin in 60 per cent alcohol. The differential count was as here appended:

Small mononuclear lymphocytes	72.75
Large mononuclear lymphocytes	12.50
Neutrophiles	14
Eosinophiles	1

Normoblasts and megalocytes were more numerous than ordinarily found in this type of leukæmia. Polychromophilic erythrocytes were occasionally seen.

The size of the spleen and glands increased with remarkable rapidity, the spleen occupying a large part of the abdominal cavity, extending to the crest of the ilium and two inches to the right of the median line. The abdomen distended with fluid. The exploratory

needle marked the fluid as blood. On examination it was found to have the same characteristics as blood withdrawn from the ear. The effusion withdrawn from the chest was also similar to other specimens withdrawn for examination. Around the seat of puncture in the abdominal wall a large hemorrhage into the skin followed. Ecchymotic spots on the lower limbs, rapidly coalescing and forming large livid areas, finally involving the entire lower part of the abdomen and lower limbs. Extreme tenderness over the sternum was a distressing symptom.

Ophthalmoscopic examination by Dr. Harry Friedenwald, September 7.—Slight pallor of both papillæ. No exophthalmos. No effusion. Slight hemorrhage into the ocular conjunctiva. These symptoms persisted with varying intensity until September 11, when violent nasal hemorrhages, hemorrhages into the skin giving the entire body below the ensiform cartilage a black appearance, enormous distension of the abdomen, vomiting of large quantities of blood, added to the patient's discomfort. On Sept. 15, after several convulsions, the patient died.

It is to be deplored we were deprived of the inestimable value of a post-mortem. The family was an orthodox Hebrew one, according to whose laws the mutilation of the dead body is prohibited.

The following salient features make this case one of extraordinary worth:

The remarkable rapidity with which the blood changes followed the enlargement of the spleen and glands has been but rarely noted, the splenic tumor preceding any changes in the blood. Even at the height of the glandular enlargement there was no coalescing of the glands, a marked characteristic of this malady. The persistent hemorrhages into the skin, pleural and abdominal cavities. No change in the ophthalmoscopic appearance of the eye in spite of the marked blood changes. It is worthy of note that this disease, rare as it is, has been twice observed at this hospital in Russian Jews, naturally suggesting the question whether or not there may be any predisposition to the disease in these people.

REPORT OF A CASE OF UTERINE FIBROIDS WITH COMPLETE PROLAPSE OF THE UTERUS.

FROM THE CLINIC OF DR. THOMAS OPIE.

BY DR. E. H. EWING, '97.

The patient, an unmarried colored girl, aged 25, was admitted to the Baltimore City Hospital, January 17, 1898. She was one of seventeen children, eleven having died of tuberculosis; parents living, the mother suffering from tuberculosis. The patient showed the results of rachitis in early childhood, there being a decided deformity in the bones of the legs, the tibia being bent forward in their middle third. She menstruated first when fifteen and suffered greatly from headaches and pains in the back and abdomen. Three months later a partial prolapse of the uterus occurred. This has lasted ten years, being complete when she entered the hospital. The patient complained of constant "bearing-down pains," dysmenorrhea and constipation.

On examination the uterus was found completely prolapsed, as stated, and further bimanual investigation showed the presence of a large fibroid attached to the fundus of the uterus. An operation for the removal of the fibroid was advised before performing any plastic operation for the correction of the prolapse.

The patient was given hot vaginal douches daily and the uterus retained in place with cotton tampons. Salines were given to regulate the bowels, and the day before operation an abdominal poultice of soap was applied and magnesium sulphate given. The urine was examined and found normal January 27. Preparations were made for a hysterectomy or myomectomy, as circumstances might warrant.

Chloroform was administered and the abdomen shaved and washed with permanganate of potash, oxalic acid and bichloride of mercury 1-2000. An incision was made in the median line of the abdomen and the peritoneum opened. A large fibroid was found on the left side of the fundus of the uterus, and smaller fibroids on the anterior and posterior walls. It was decided to perform the

more conservative operation—that of removal of the growths only. An incision was made through the capsule of the largest fibroid and the tumor turned out. It was spherical and four inches in diameter. The resulting flaps were cut away partially and united by No. 4 braided silk sutures, considerable hemorrhage occurring; pressure was successfully applied by sponges. Two smaller fibroids were similarly removed from the anterior and posterior walls of the uterus. The abdominal cavity was dried by sponging with gauze, and the parietal wound closed with a single row of silkworm sutures and dressed with gauze, collodion and adhesive plasters. The patient was but little shocked and rested well the first night, morphia gr. $\frac{1}{4}$ being given hypodermically. The urine was drawn by catheter eight hours after operating, being passed normally afterwards. Teaspoonful doses of milk were given during the night. The second day an enema of salts and glycerine was given and the patient placed on a strict liquid diet, which was continued six days.

At no time did the temperature rise above $99\frac{1}{2}$, nor the pulse above 88. Lactic pills were given to regulate the bowels and the diet gradually increased. On the fourteenth day the stitches were removed and the wound, which had healed perfectly, redressed with gauze and plasters.

On the twentieth day the patient was allowed to sit up, an additional bandage having been applied to support the abdomen. Three days later she was walking about with much comfort, the pains having disappeared and the prolapsed condition, while not entirely relieved, greatly improved.

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THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

THE JOURNAL.

The JOURNAL of the Alumni Association has been established by the officers and executive committee to bring into closer relations the alumni who are scattered widely over the world. While it remains under the present management it will be conducted solely in the interest of the Association, and the degree of success which it will attain will depend upon the interest shown by the alumni.

It is expected that nearly all medical papers published will be from the pens of alumni, but other matter thought to be of interest will not be excluded. Papers and reports of cases will be gladly received from an alumnus anywhere. Members who publish their papers elsewhere are especially requested to send to the JOURNAL a reprint or an abstract, so that due note can be made of it in the JOURNAL.

It is always a great advantage to the reader of a scientific article to have a personal knowledge of the writer. This will be one of the JOURNAL's great advantages over ordinary medical journals, because a large number of the readers already have an acquaintance with every contributor to the present number and also with future contributors.

In each number considerable space will be devoted to personals. Under this head an effort will be made to keep the members of the different classes informed as to where their old classmates are and what they are doing. Great assistance can be rendered this department by each alumnus sending in his own record and that of any others of whom he may know.

SEMI-ANNUAL MEETING.

PRESENTATION OF PORTRAIT OF DR. ARNOLD TO THE MEDICAL AND CHIRURGICAL FACULTY.

In accordance with a wide-spread desire, the first semi-annual meeting of the Association was held, October 20th, '97, at the hall of the Medical and Chirurgical Faculty of Maryland.

The exercises began with an address by Dr. A. B. Arnold (see page 1 this Journal). This was followed by the presentation of the portrait of Dr. Arnold by the members of the Alumni Association to the Medical and Chirurgical Faculty.

Dr. Harry Friedenwald, president of the society, made the following remarks:

Mr. President and Officers of the Faculty and Alumni of the College of Physicians and Surgeons:—Many of the Alumni of our College have felt that in this hall, which is to become the Pantheon of Maryland's illustrious physicians, few are more deserving of an honorable place than the one who has just honored us with his address. In presenting his portrait to the Medical and Chirurgical Faculty we, the Alumni, desire not only to show our appreciation of the merits of a teacher who has our unalloyed attachment, but also our respect for this Faculty, which has at all times represented what was most honorable and what was highest in our profession.

The portrait which I present in the name of the Alumni is one of the best works of a distinguished artist, Mr. L. N. Dietrich; it reproduces the genial features of our friend with marvelous accuracy.

At an occasion such as this it is fitting that we should recall some of the more important characteristics of the life of him whom we would show honor. The presence of Dr. Arnold among us to-night, while rendering this more difficult, has the advantage, besides others more important, that if any of my data are wrong he can easily correct them. To begin, therefore, let me tell you that Dr. Arnold was born in Germany in 1820. He graduated at the Washington University in 1848, and is therefore one of our oldest living alumni.

After practicing a number of years in Pennsylvania he returned to Baltimore, and for many years was one of our busiest practitioners. In spite of an extraordinarily large practice, Dr. Arnold found time and had the heart to do more work among the poor than most of the physicians of his time. Like Dr. MacLure of "Beside the Bonnie Briar Bush," he has brought comfort and solace and happiness into many a home. Ever—

"serene,
When grief and anguish cloud the anxious scene,
Each look, each movement, every word and tone
Telling your patient you are all his own;
Not the mere artist purchased to attend,
But the warm, ready, self-forgetting friend,
Whose genial visit in itself combines
The best of cordials, tonics, anodynes."—Holmes.

In our medical societies he was a leader. He read numerous papers, but he was most frequently heard in discussions. In this Medical and Chirurgical Faculty he held many offices, and was its president in 1877-78. As a medical teacher he occupied first the chair of Principles and Practice at the Washington University (from 1870-77), and after its consolidation with the College of Physicians and Surgeons, the chair of Clinical Medicine and Diseases of the Nervous System in the latter institution. He held this position until about 1890, when he relinquished his practice and left Baltimore to reside in San Francisco. But the beauties of the western city were not sufficient to balance the attractions of his old home, and we are fortunate in again having him among us.

It is needless to tell you how attractive his lectures were, how engrossed he was in his subject, how he put his whole active energy into his teaching, how clearly and vividly he pictured disease, how thoroughly he absorbed the attention of his classes. He was a frequent contributor to our literature. One of his essays obtained the prize at the Baltimore Academy of Medicine, and his text-book on "Diseases of the Nervous System" was of great value to many students.

During the last few years he has devoted himself to philosophical and literary studies, enjoying well-earned rest after years of difficult

and laborious work. Of him we may say, in the words of Holmes, he is now seventy-seven years "young."

"Call him not old, whose visionary brain
Holds o'er the past its undivided reign;
For him in vain the envious seasons roll
Who bears eternal summer in his soul."

We delight in seeing him in the full enjoyment of health and mental as well as bodily vigor, and trust that many years of this enjoyment of life may be in store for him. We are happy in having been able to assure him this evening of the affectionate place he occupies in our hearts.

Dr. Charles Ellis, of Elkton, Md., the president of the Medical and Chirurgical Faculty, accepted the portrait on behalf of the Faculty.

A very enjoyable smoker followed. Besides a large number of Alumni, many of the officers of the State Faculty were present.

Personal Notes.

DR. J. H. DRAWBAUGH, '86, stopped off for a short call on returning from Washington, D. C., February 21. He is located at Robeson, Pa., and is enjoying a good practice.

DR. S. A. STONE, '86, of Monongah, W. Va., has been in the city several weeks doing post-graduate work. He was also trying to obtain a good assistant to help him in his practice.

DR. FRANK DYER SANGER, '88, has been elected Clinical Professor of the Nose, Throat and Chest in the College and also Secretary to the Dean.

DR. L. L. DOANE, '86, is located at Meadville, Pa. For two years he was on the staff of the State Hospital at Warren, Pa. In 1890 he received the degree of Ph. D. from Allegheny College. He is making a specialty of the eye, ear, nose and throat.

DR. N. T. CARSWELL, '86, and DR. PEARL WILLIAMS, '96, are spending a year studying in Europe. When last heard from they were in Vienna.

DR. RICHARD F. GUNDRY, '88, is making a great success of his sanitarium, "The Richard Gundry Home," for the treatment of mental and nervous diseases. His old classmates will be glad to hear of his success.

DR. CHARLES E. GREENE, '91, is now in Baltimore as a special representative of the Chas. H. Phillips Chemical Co., whose products are already so favorably known to the profession.

DR. JOHN RUHRÄH, '94, has been appointed Quarantine Physician to the port of Baltimore.

DR. C. HAMPSON JONES, '91, was appointed Health Commissioner for Baltimore City, and took charge of the office March 14, 1897.

DR. HARRY FRIEDENWALD, '86, has been appointed surgeon to the Baltimore Eye and Ear Charity Hospital.

DR. J. J. CLOONAN, '97, and his silk hat were at the City Hospital February 25th. The Doctor is located at Stamford, Conn., and is the examiner for the John Hancock Life Insurance Co.

DR. J. A. MOORE, '85, is doing a flourishing county practice at Six Mile, Bibb Co., Ala.

DR. O. T. BOND, '79, was president of the Board of Pension Examiners at Clarksburg, W. Va., until he resigned in May, 1897.

DR. THOS. H. BRAYSHAW, '85, is in Anne Arundel Co. only about ten miles from Baltimore. Tom's genial temper, which made so many friends for him when a student, has been a large element in his marked success as a practitioner.

DR. J. C. F. BUSH, '84, is surgeon to the U. P. and also to the F. E. and M. V. Railroads, at Wahoo, Nebraska.

DR. J. J. MORRISEY, '97, is an assistant resident physician at the Boston City Hospital.

DR. J. J. MCCARTHY, '96, has been in Baltimore several weeks representing a large manufacturing chemist of his native town of Naugatuck, Conn.

DR. EDWARD FITZGERALD, '84, of Bridgeport, Conn., has been elected a member of the New York Academy of Medicine. The Doctor is gynecologist to the Bridgeport Hospital.

DR. C. H. BAYARD, '92, is making an effort to organize the Alumni located in New England into a local association for mutual benefit. His address is Orono, Maine.

DR. WILLIAM P. SPRATLING, '86, Medical Superintendent of the Craig Colony for Epileptics at Sonyea, N. Y., has recently published an interesting paper, in which he suggests the desirability of "The Formation of a National Society for the Study of Epilepsy and the Care and Treatment of Epileptics."

A summary of its proposed work may be stated to be as follows:

1st. The scientific study of epilepsy.

2nd. The rational treatment of the disease.

3rd. The best methods of caring for dependent epileptics, including: *a.* The construction of proper homes, based upon a study of the epileptic's needs as to classification and environment. *b.* The study of the utilization of the epileptic's labor, for economic, scientific and ethical reasons. *c.* The study of the best educational methods to be employed, including manual, industrial, intellectual and moral forms and forces.

In such a society, science, philanthropy and practical charity may well combine for a common purpose. With a view to ascertaining, in a measure, the desirability of the organization of such a society, thirty-five circular letters were sent to physicians and others who might be interested in the matter. To these thirty replies were received, as follows: In favor of, 23; neutral, 3; opposed, 4. It is thought now that an effort will be made to organize the society in May next. We wish Dr. Spratling success in this excellent undertaking.

H. F.

DR. WILLIAM BAIRD CLARK, '90, died of typhoid fever at his home at Cannonsburg, Pa., July 18, 1897. Dr. Clark was at one time assistant resident physician at Bay View, assistant physician at the Quarantine Hospital of the port of Baltimore, and for one year assistant surgeon of the Maryland Steel Company. Afterwards he spent two years studying in Europe, and on January 1st, 1897, opened an office in Pittsburgh, limiting his practice to diseases of the eye.

DR. GEORGE THOMAS, '82, died at his apartments at the Severn, June 3d, '97. He had been for many years secretary to the Dean, and for the past four years clinical professor of laryngology. In 1889 he was married to Miss Elizabeth Hammond, daughter of ex-Judge Edward Hammond of Howard County, who with two children survive him.

The following resolutions were unanimously adopted at a meeting of the Alumni Association, held June 16, 1897:

Whereas, The Alumni have heard with great sorrow and distress of the recent death of their esteemed colleague, DR. GEORGE THOMAS, who was taken from their midst in the prime of life and at a time of great usefulness; therefore be it

Resolved, That having known Dr. Thomas both socially and professionally, they feel his loss most keenly, and that in his death the profession has lost a most able, scientific and conscientious physician, and the Association an active and useful member, of whom it had just reason to be proud.

Resolved, That they tender to his family their sincere and heartfelt sympathy.

FRANK G. MOYER, M. D., Chairman.

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Announcement of Meeting.

The officers of the Association have arranged Clinics to be held on the two days preceding Commencement Day, as follows:

TUESDAY, APRIL 12TH, 1898.	WEDNESDAY, APRIL 13TH, 1898.
12-12.30. Medical Clinic. DR. T. S. LATIMER.	12-12.30. Gynecological Clinic. DR. W. S. GARDNER.
12.30-1. Surgical Clinic. DR. CHAS. F. BEVAN.	12.30-1. Demonstration of Pasteur Treatment. DRS. KEIRLE and RUHRAH. Dermatological Clinic. DR. W. F. SMITH.
1-1.30. Ophthalmic Clinic. DR. H. FRIEDENWALD.	1-1.30. Neurological Clinic. DR. G. J. PRESTON.
1.30-2. Surgical Clinic. DR. J. W. CHAMBERS.	1.30-2. Gynecological Clinic. DR. OPIE.

The *Meeting* of the Association will take place April 13th, at 8 P. M. sharp, at the Eutaw House. It is important that a large number of members attend.

The *Banquet* will follow at 9 P. M. at the Eutaw House. Tickets may be obtained from the Treasurer, Dr. Brack. Price \$2.50.

The *Commencement* will be held at Ford's Opera House, April 14th, at 12 M. The orator will be Rev. W. F. JUNKIN, D. D., of Mt. Clair, N. J.

Tickets of admission will be reserved for those who apply before April 10th, to DR. BRACK, City Hospital, Baltimore.

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Secretary.

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Vol. I

No. 2

JULY, 1898

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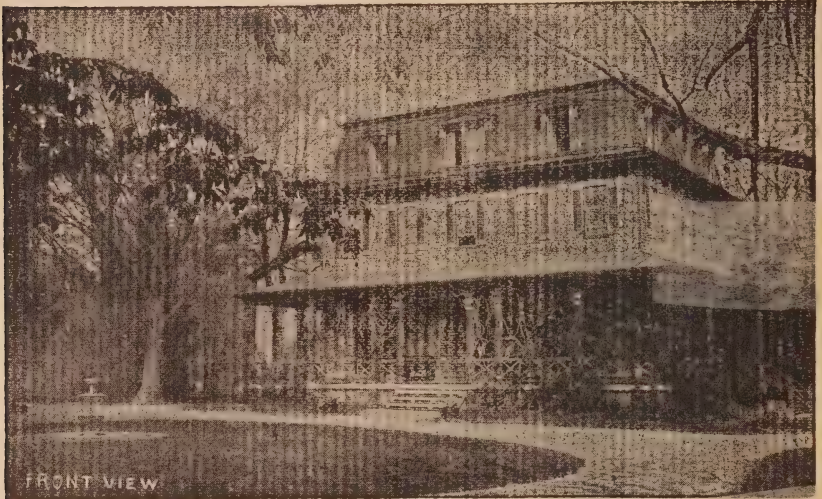
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Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Personal Notes.

DR. U. E. G. DYER, '92, is located at Star, Texas. He has been appointed Notary Public by the Governor, and is secretary and treasurer of the Mills County Medical Society.

DR. WM. H. FOCHT, '83, is practicing at Tiffin, Ohio. He is a member of the American Medical Association, Fellow of the American Academy of Medicine, and for the past four years has been secretary of the Board of Pension Examiners at Tiffin.

DR. HARVEY G. BECK, '96, spent the summer of '97 in Europe. He is now located in Baltimore.

DR. C. M. WARWICK, '87, is practicing with his father at Lucasville, Ohio. "Charlie" has been married for several years.

(Table of Contents on Page V.)

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Personal Notes.

DR. JAS. S. GILBERT, '86, has been for several years Mayor of the City of Bordentown, N. J.

DR. H. F. FREEMAN, '78, is located at Taylor, N. C. The Doctor has been a Justice of the Peace, member of the State Senate in 1891, and was elected to Congress in 1896. He is a member of the Wilson County Medical Society.

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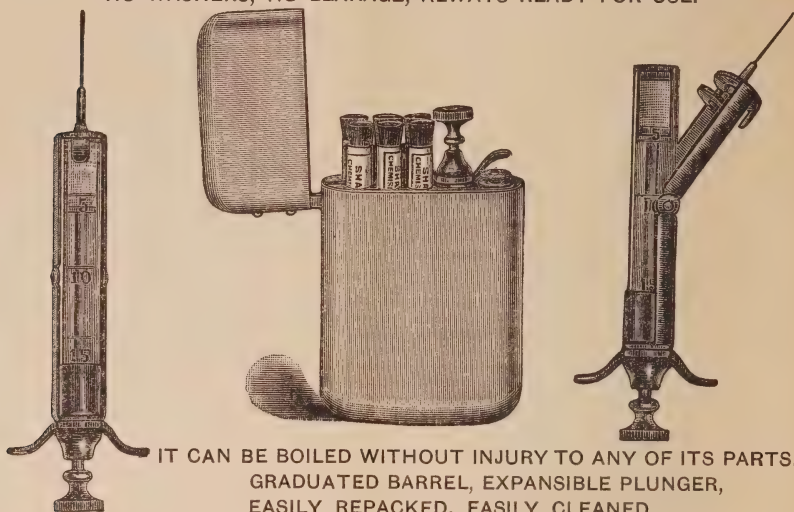
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THE JOURNAL
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ON THE IMPORTANCE OF RECOGNIZING HYPERTROPHY OF THE PHARYNGEAL TONSIL.*

By DR. FRANK DYER SANGER, '88.

The activity of the lymphatic system of young life may be said to be one of the prominent characteristics of this period. It is due, of course, to the rapid metabolism belonging to growth and development. Because the skin and mucous membranes are much more vulnerable in young life, the lymphatic structures are apt to be overtaxed, and enlargements of these tissues are notoriously common. Particularly is this true of the lymphatic structures that drain the nose and mouth. The lymphatics in the vault of the pharynx have a great deal of work to perform, draining, as they do, the connecting space between two cavities which from a bacteriological standpoint are not cleanly in the adult, and in the child are apt to be less so, because in the child measures pertaining to the toilet of the nose and mouth are so frequently neglected.

While the tendency to lymphatic hypertrophy seems to be more marked in certain families, it is not probable that hypertrophy of the pharyngeal tonsil is an inherited condition, but the pre-existent

* Extract from lecture delivered March 1st.

state upon which the hypertrophy depends is in all probability transmitted, since quite frequently the parents give a history of nasal or post-nasal trouble; nor are all of the children who suffer from enlargement of the pharyngeal tonsil strumous, though a large number of cases occur in children of this type.

There seems to be little doubt that inflammatory changes in the nasal passages are etiological factors of importance; and the frequency with which such enlargements follow measles, whooping cough, and particularly scarlet fever, shows the importance of their role.

Hypertrophy of the pharyngeal tonsil assumes a position the dignity of which is hardly equaled by enlargement of other lymphatic structures, by reason of its anatomical location, situated, as it is, in the vault of the pharynx, between the eustachian tubes and in close proximity to the choanæ. The symptoms produced are largely mechanical. Probably the most important symptom is nasal obstruction, the extent of which depends upon the degree of hypertrophy, and to a limited extent upon the shape of the vault, as was suggested by Dr. Harrison Allen.

Occasionally enlargements that can be seen and easily felt do not obstruct the nose sufficiently to produce marked oral breathing, but usually the mouth remains open at night, and in severe cases during the day as well, and all the distressing results of mouth-breathing quickly follow. The entire respiratory tract below the naso-pharynx is subjected to the irritation of air not properly warmed, not moistened, and unfiltered, which leads sooner or later to inflammatory processes either in the larynx, trachea or bronchi. The nasal cavities and accessory sinuses fail to be aerated, and developmental changes may take place here. Such individuals usually have characteristic expressions, dependent upon these changes. The nose is usually broad at its base, giving the eyes the appearance of being wider apart. The arch of the palate becomes greater and the teeth are thrown out of their normal lines. The lips become prominent, and the constantly open mouth gives the patient a semi-idiotic expression; indeed this expression is not always merely apparent, for mental hebetude characterizes a certain number of these individuals, as pointed out by Dr. Guye of

Amsterdam, and particularly is this true when deafness is a concomitant.

Prolonged interference with nasal respiration in the growing child strikes at the root of all metabolism by interfering with oxidation processes. Such children are usually anæmic and do not grow at the normal rate, and thus a vicious train of events is lighted up whose end no one can predict. For who can estimate the results of interference with the physical development of a child? Does not his mental equation depend upon his physical quota, and will not both be handed down to posterity? The dire results of nasal obstruction are best illustrated by the marked changes for the better which immediately follow the removal of the obstruction. Such children begin at once to grow and develop, the expression improves, the hebetude disappears, and the child is, as it were, transformed.

Some other results of obstruction are inability to blow the nose, dryness of the throat, headache (perhaps due to circulatory disturbances), noisy respiration (snoring) at night, night terrors, restlessness, and often drowsiness during the day; occasionally stridor or cough exists. Attacks of asthma have also been attributed to this condition. Young infants have difficulty in taking the breast on account of being unable to breathe through the nose. In certain children nervous manifestations make their appearance. There is in many instances marked change in the disposition of the child, usually in the direction of irritability. Even chorea is said to have occurred as a result of these growths.

Next to nasal obstruction the ear complications, which are in all probability also largely mechanical, are important. The enlarged lymphoid tissue may not actually occlude the more or less cartilaginous eustachian tube by pressure, but it probably interferes considerably with the action of the muscles concerned in opening these tubes, especially with the tensor palate, since it arises from the internal pterygoid plate, and thus the middle ear fails to be aerated. It is the consensus of opinion among aurists that a large percentage of cases of acute catarrhal otitis media in young life are due to these hypertrophies. Meyer of Copenhagen, who, twenty years ago, wrote the

first precise account of hypertrophy of the pharyngeal tonsil, found that 74 per cent of his cases of hypertrophy suffered from deafness. Eight years before Czermac called attention to the difficulties occasionally encountered in introducing the eustachian catheter by reason of comb-like masses in the naso-pharynx. Deafness, earache, tinnitus are common among these children; and when deafness occurs early in life, if it is at all pronounced, dumbness is always a terrible possibility.

Not long ago a mother brought her boy of nine or ten to me, giving the history that when the little fellow was four or five years old he had scarlet fever, and following it suffered much from earache and became progressively more and more deaf. He soon stopped talking. When I saw him his expression was typical, his mouth open, his face lacking in intelligence, his breathing was loud and noisy, his faucal tonsils were enlarged, and the vault of his pharynx filled with hypertrophied tissue. I asked Dr. Harry Friedenwald to examine his ears, and he reported to me that there was great retraction of the tympanic membranes and very little hope of benefiting him. I removed his faucal tonsils and cleared out the vault of his pharynx, but it was too late; he is now being taught lip speech in a school for the deaf and dumb.

Aside from the loss of speech which results from deafness, children who suffer from enlargement of the pharyngeal tonsil usually manifest some modification of voice, due in part to obstruction, giving the voice a peculiar dead sound; but due also to interference with free movement of the soft palate and uvula. *p* is usually pronounced like *b*, and *t* like *d*; *m* and *n* become *eb* and *ed*.

The sense of smell is often impaired, because of failure of odoriferous particles to reach the olfactory nerve. Taste also diminishes as a result of the loss of the sense of smell and because of the swelling of the mucous membrane of the soft palate.

One of the most disagreeable symptoms met with in connection with hypertrophy is the excessive tough greenish or yellowish mucous or muco-purulent secretion which accumulates in the vault of the pharynx, finding its way at times through the nose, but usually dropping down into the lower pharynx, to be swallowed or expelled from

the mouth. In the morning the pillow-case is often found stained with this material. Upon rising sufferers spend some time hawking and spitting before the accumulated secretion is gotten rid of.

Obstruction in the vault of the pharynx from enlargement of the lymphatic tissue occurs occasionally in infants, but the most frequent period is between five years and puberty. After puberty such growths usually tend to disappear, though occasionally they have been met with after the age of twenty. It is during this period that the mental and physical status of the individual is being determined. How important it is, therefore, that the child should be guarded against a condition that may influence his or her future so profoundly as the one under consideration. The late Morell Mackenzie thought that the importance of lymphatic enlargements in the vault of the pharynx was exaggerated. If such enlargements only menace so important an organ as the ear they cannot be taken too seriously.

The question of diagnosis is a comparatively simple one. To one accustomed to posterior rhinoscopy the diagnosis is usually easily made. In fact those who see these cases frequently can, in many instances, predict the condition with a considerable degree of positiveness from the appearance and speech of the child. The method of diagnosis which is most useful to the greatest number of practitioners is, however, by digital examination. The only requisite is a finger knowledge, so to speak, of the normal vault, which can be easily acquired by making a few examinations of healthy children. There can be no objection to such an examination if it is done gently with a clean finger. Standing at the back of the child, whose arms had best be held, the examiner presses the left cheek between the teeth well back, supporting and fixing at the same time the head between the left wrist of the examiner and his body. In this manner the child is not only held fast, but is unable to close the teeth upon the examining finger, a disagreeable complication which should always be carefully avoided. The index finger of the right hand is then introduced and carried well back till its tip is hooked behind the soft palate. Care should be taken not to carry the soft palate backward and up toward the vault. With the posterior edge of the vomer as

a guide, the finger is carried up into the vault and the entire vault explored. The soft pulpy, slightly pedunculated masses have a very different feel from the firm, slightly elevated and only slightly irregular normal vault.

Other methods of examination are used by the laryngologists, but none are so generally useful as the one described.

525 N. Charles Street.

THE VAGINAL OPERATION FOR EXTRA-UTERINE PREGNANCY.

BY DR. WILLIAM S. GARDNER, '85.

Cases of extra-uterine pregnancy which have been operated upon by the vaginal route may be classed in four divisions:

1. Cases in which rupture has taken place, but the active hemorrhage has stopped.
2. Cases in which rupture has taken place and the active hemorrhage continues.
3. Unruptured cases.
4. Operations undertaken for the extraction of the child at full term.

The following cases belong to the cases of the first division.

Case 1. M. G., aged thirty-seven, mother of seven children. The last child was born in July, 1895, and nursed until the last of July, 1897. Her menses were regular from the time of confinement until about the first of July, when the period was three days over time. She then began to bleed freely, and continued to do so until admitted to the hospital, August 7, 1897. During all this time she complained of pain, which was greatest on the left side, but there was no history of the extremely severe pains so commonly associated with rupture of an extra-uterine pregnancy.

The uterus was found to be enlarged and pushed forward, the cervix being close to the symphysis. Behind the uterus was a large fluctuating mass completely filling Douglas' cul-de-sac and extending

above the brim of the pelvis. A little blood was still coming from the uterus.

A diagnosis of ruptured extra-uterine pregnancy was made. Since the rupture had evidently taken place five or six weeks before admission to the hospital, and there seemed to be no immediate danger, the operation was postponed until the next day.

August 18 the patient and instruments were prepared for both vaginal and abdominal operations. The uterus was curetted and then free incision was made through the posterior vaginal wall. A considerable quantity of fluid blood at once poured out. The fingers were then inserted through the opening and a large quantity of clots turned out. The cavity extended into both broad ligaments, but more deeply into the left one.

No fetus was found, but chorionic villi were found in some of the *débris* removed from the left side. The cavity was loosely packed with iodoform gauze. This was removed in forty-eight hours and not replaced. As soon as the patient recovered from the anesthetic she expressed herself as feeling much better than at any time during the past six weeks. Her convalescence was absolutely uneventful. She left the hospital ten days after the operation.

Case 2. Mrs. S., aged thirty-two, II-para; the last child was born November 14, 1896, and was nursed only two weeks. She menstruated regularly until October 29, 1897. During the latter part of November she had some nausea, and her menses not coming on at the regular time she suspected that she was pregnant. About December 5 she began to bleed some, and on December 8 she sent for Dr. W. E. Miller and complained of the continued bleeding and more than the usual amount of pelvic pain. The pain and hemorrhage continued more or less until early in January. Just about one month after the symptoms began a tumor was noticed rising from the pelvis above the brim and plainly felt through the lower part of the abdominal wall. During this month her temperature was continuously a little above normal. The pain had continued, and when severe had been controlled by morphia.

I saw the patient in the evening of January 8. She then had a

tumor, with clearly defined outlines, rising from the pelvis and more prominent on the right side, extending half way to the umbilicus. By the vagina it was found that the uterus was only slightly enlarged and pushed forward close to the pubes; the pelvis was apparently filled with a tense mass that fluctuated but slightly.

It was perfectly clear that we had to deal with a tumor containing fluid that could be relieved only by operation, and that the most advantageous method was by the vagina. The next morning, under anesthesia, a long incision was made into the posterior vaginal wall. This incision was enlarged by the fingers and a large quantity of fluid and clotted blood evacuated. The cavity was packed with sterilized gauze. There is little to note of the convalescence. Some difficulty was encountered in keeping the incision freely open for drainage, but this was accomplished, and the patient made a very satisfactory recovery.

Case 3. Mrs. F., aged thirty-five; no children at full term; three miscarriages, each about the second or third month of gestation, the last miscarriage about March, 1896. Her last regular period was December 15, 1897. The flow came again January 15, and continued during the remainder of the month and through February, but she did not call her family physician, Dr. Zepp, until March 5. During all this time she continued to have periodical attacks of pain, and suffered considerably from time to time with distension of the intestines. At this time Dr. Zepp found a lump just above Poupart's ligament, which was elongated about the size of the fist and parallel with the right ligament. The pelvic structure, examined by the vagina, was very sensitive to pressure, and a soft tumor was felt posterior to the uterus. Dr. Zepp attended her alone for two weeks. In these two weeks she had much pain on defecation, but was able to urinate with little difficulty except for a slight burning.

March 18 the patient was seen by Dr. Chambers, who made a diagnosis of ruptured extra-uterine pregnancy. Through him I saw the patient, with Dr. Zepp, March 19. The general condition of the patient, so far as pulse, temperature, respiration and appearance, was good. She was still bleeding a little and had had a severe attack of

pain early that morning, which had been controlled by morphia. The abdomen was so much distended by inflated intestines that a satisfactory examination could not be made without anesthesia.

She was at once put under an anesthetic, and the uterus, about normal in size, was found pushed firmly against the pubes. A large, fluctuating mass filled the pelvis and extended from above the pelvic brim. The portion extending into the abdominal cavity had a clearly defined outline.

A long incision was made in the posterior vaginal wall, and about a quart of blood, mostly fluid, was evacuated. The opening made was sufficiently large to admit three fingers. The clots were removed and the cavity packed with a large piece of sterilized gauze. This gauze was removed by Dr. Zepp at the end of forty-eight hours and not replaced. Dr. Zepp had charge of the patient during her convalescence, which was perfectly satisfactory. She was out of bed in two weeks.

Case 4. Mrs. C., aged thirty-one; has had three children and four miscarriages. The last three pregnancies terminated in miscarriages, the last one occurring in April, 1897. From that time her menses were regular up to February 5, 1898, the date of her last regular period. On March 26, just seven weeks after the period, she began to have some pelvic pain, and on the 27th a discharge of blood made its appearance. From this date until I first saw her, April 21, a period of nearly four weeks, she had a constant but not profuse flow of blood from the vagina, had suffered almost constantly from pain and had been confined to the bed nearly all the time.

Upon examination it was noted that the patient was thin and anemic; the pulse was rapid, but there was no rise of temperature. A tumor with a clearly definable upper boundary, more prominent on the right side, rose in the median line five inches above the pubes. The enlarged uterus was forced forward and upward, while behind it a large, fluctuating tumor was felt. Dr. Hayden, the attending physician, assured me that the tumor in the lower part of the abdomen had been present only three or four days. A diagnosis of ruptured extra-uterine pregnancy was made.

April 22, under anesthesia, a long incision was made in the posterior vaginal wall and a large quantity of clotted and fluid blood evacuated. The cavity was packed with a large piece of sterilized gauze. This gauze was removed on the 24th.

This patient had some secondary hemorrhage, which was probably due to the too sudden removal of the gauze packing, but has made a complete recovery.

It should be borne in mind that these cases all belonged to one class—those in which the rupture was into the broad ligaments and when the active hemorrhage had probably ceased. The whole number of cases operated upon by this method is small, but the uniform success achieved by all operations is the best index of its value.

DIFFERENTIAL TESTS FOR ALBUMEN.

By DR. HARVEY G. BECK, '96.

The mere presence of albumen in the urine does not signify, as is generally conceded, only an inflammatory condition of the cells in the kidney as in nephritis, but it serves as an index in disclosing the true nature of many morbid processes in the various organs of the body, depending upon the form of albumen and other pathological elements present in the urine. It therefore is essentially important that we are enabled to detect and differentiate the various forms as they exist in the urine if we would derive any data for making a correct diagnosis. There are four of these albumens often encountered in pathological urine which have an important clinical bearing, often existing singly, but not infrequently several are associated.

These are: 1. Serum albumen. 2. Nuclear albumen. 3. Albumosis. 4. Peptone. They have their source more or less independently of each other, and occur under different morbid conditions.

1. *Serum Albumen* is present in a dissolved state in the blood, which contains 4 or 5 per cent. As long as the kidney epithelium is normal it cannot penetrate. If any structural change takes place in the kidney epithelium it enters the uriniferous tubules and escapes

in its soluble form with the urinary excretions. This condition we call Albuminuria, in contradistinction to nucleo-albuminuria, albumosuria, peptonuria, etc.

2. *Nuclear Albumen* or mucin is formed by the destruction of the desquamated epithelial cells in the urinary passages. A small quantity is present in the normal urine, in the cloudy sediment produced after standing. It is increased:

a. In catarrhal processes of the urinary passages, *e. g.* urethritis, cystitis, pyelitis.

b. In the beginning and ending of every acute nephritis.

c. In acute infectious diseases with fever.

d. In jaundice and diseased processes of the gall bladder.

3. *Albumosis* is an intermediate product in the process of digestion of proteid substances in the stomach. They are first changed by hydrochloric acid into acid albumen, then by pepsin into albumosis or propeptone, and finally into peptone.

We find albumosis:

a. In tumors of the marrow of the bones.

b. Leukaemia.

c. In the acute exanthemata, especially in scarlet fever.

d. In infectious diseases.

e. In stomach and liver affections.

4. *Peptone* is the end product in the digestion of albuminous substances. It never exists normally in the blood or urine. It enters the circulation if there is a destruction of physiological or pathological tissue and this becomes absorbed.

We find peptone:

a. In ulcerative processes of the intestines, as in typhoid fever, but not in tubercular ulceration.

b. In fever. In pneumonia it occurs at the time of crisis and is a good sign. It is an unfavorable sign in acute articular rheumatism if there is a heart complication.

c. During parturition.

d. The most important is the appearance of peptone in the urine in suppurative diseases, as in pyemia, suppurative meningitis, suppur-

ation in the joints, abscess of the liver, appendicitis, suppurative peritonitis, etc. In these conditions it is generally associated with a polynuclear leucocytosis in the blood.

Peptone does not occur:

- a. In nephritis.
- b. In tuberculosis.
- c. In leukaemia.

The tests necessary for the recognition of the various proteid substances and their differentiation are few, simple, and generally familiar. They must, however, be carefully and consecutively applied.

Probably the most easily comprehended and practical method is the one taught by Dr. Victor Neudörfer, of Vienna, in which he describes but five tests and speaks of them in their numerical order as test I, II, III, etc.

Test I. Heat test. Precipitation occurring after heating may be serum albumen or earthy phosphates. After the addition of a few drops of nitric acid, the precipitate disappears if due to the phosphates, but it remains, becoming even more distinct, if due to albumen.

II. Nitric acid test. By carefully adding a layer of nitric acid a precipitate is formed of acid albumen. From the size of the ring an approximate estimation can be made of the amount present. Test should be made in a test cup.

III. The most delicate test. Add to the urine acetic acid in excess and a drop of potassium ferrocyanide; when traces of albumen are present a distinct precipitate is formed.

IV. Biuret test. Add sodium hydroxide in excess and a few drops of sulphate of copper solution; a purple violet color forms.

V. Add to the urine dilute hydrochloric acid in excess and a 30 per cent. solution of sodium chloride. A precipitate is formed, disappearing on heating and reappearing on cooling.

In testing for nuclear albumen add to the urine acetic acid. If nuclear albumen is present a precipitate occurs at once which is dissolved in an excess of the acid. On adding a few drops of potassium ferrocyanide a second precipitate is formed if serum albumen is also present, but no precipitate in case it is only nuclear albumen.

Albumosis reacts with tests II and III, but not with I. Test V is decisive.

Peptone does not react with tests I, II and III, but it gives a reaction with IV, the biuret. It is only decisive for peptone if no serum albumen is present in the urine. When both exist in the same specimen the serum albumen must first be removed, which can be accomplished by boiling the urine and filtering.

To summarize: In examining urine for albumen, begin with test III. If this is negative, the presence of nuclear albumen, serum albumen and albumosis can at once be excluded. The only proteid which may be present is peptone. This we determine by the biuret test. When test III is positive it may be serum albumen or albumosis; decide it by test I or V.

Globulin, which occurs frequently in the urine, generally associated with other forms, especially serum albumen, was purposely omitted, as it does not play an important rôle clinically and its presence does not impair the efficacy of the foregoing tests.

HYPERTROPHIC CIRRHOSIS OF THE LIVER.

FROM THE CLINIC OF DR. THOMAS S. LATIMER.

BY DR. H. WESTPHAL, '98.

February 5. W. F., æt. 22 years, laborer.

Family history. Negative. Had rubeola as child. Epileptic from early childhood. Intervals between attacks are irregular, one month to one year intervening. Since four years, aura, consisting in feeling of giddiness and interference with sight, precedes attack. Has hurt himself slightly at different times while falling. Never bit his tongue. (Tongue, however, seems to show several cicatrices.) Does not think that he utters initial cry. After attack falls into deep sleep, after which he feels weak and languid. No history of syphilis or alcoholism.

In October, 1897, noticed swelling of feet, which, gradually extending, involved legs, external genitalia and abdomen. Shortly after swelling of feet icterus appeared, accompanied by nausea.

Icterus was pronounced in a few days, while all food was immediately vomited. Vomiting was violent and very annoying. Dejecta were often bloody.

When abdomen was well distended by fluid, icterus passed away, leaving skin of abdomen and lower extremities hyperaemic and very sensitive.

By end of December was confined to house. He could not lie down without discomfort on account of dyspnoea. Sleeps propped up by pillows.

Previous to October weighed 121 lbs.; in December, 170 lbs. Has had medical attendance. Treatment: Salines. Admitted to hospital February 4, 1898.

Treatment:

Tinct. ferri chloridi 1.5—t. i. d.
Sodii et potassii tartratis 4.0 t. i. d.
Solut. potass. arsenitis 0.3 t. i. d.

February 6. *Paracentesis Abdominis.*

Analysis of Ascitic Fluid.

Quantity.....	3250 cc.	<i>Microscopical.</i> Red blood corpuscles, single and <i>en rouleaux</i> , in all stages of degeneration, cre-nated and blood shadows. Leucocytes, single and aggregated in groups of from 5 to 10. Flat epithelial cells.
Specific grav.....	1.020	
Reaction.....	alkaline.	
Color.....	dark straw.	
Odor.....	faint.	
Albumin.....	25% (Esbach).	
Sugar.		
Globulin.		
Uric Acid.		
No biliary pigment.		
(Coagulates on standing with copious fibrin formations.)		

Urinalysis.

Spec. grav.....	1.031	Few red blood corpuscles. Copious "brick dust deposit" of urates. No casts.
React.....	acid.	
Color.....	turbid-red, copious ppt.	
Odor.....	sharp.	
Albumin.		
Excess of urates.		
No biliary pigment.		

Examination of faeces.

Dark, semi-solid masses, containing a great deal of undigested food material.

Microscopical Examination.

Strings of mucus.	}	<i>No tubercle bacilli.</i>
Profusion of micro-organisms.		Spore-bearing bacilli micro-
Muscle fibres, vegetable cells and debris.		cocci.

The color of faeces being of no value on account of iron treatment, an acidulated alcohol extract was made, which gave *Urobilin reaction*.

STATUS PRAESENS. February 8. Poorly nourished. Complexion sallow and muddy. Eyes sunken. Expression anxious. Conjunctivae anaemic. Some oedema on lower extremities. Lines simulating lineae gravidarum on abdomen, also some dilated veins. Recti abdominales widely separated.

Liver. Upper border one inch below nipple line (it reached the nipple line before paracentesis). Lower border about three inches below costal arch. Not painful on palpation.

Spleen. Not palpable.

Heart. Sounds faint; no murmurs. Effusion into pericardium. Apex beat very indistinct; impulse undulating.

Lungs. Normal. Respiratory sounds somewhat rough. Effusion into left pleura, flatness reaching to third rib.

Patient feels much better after tapping and breathes much easier.

February 11. *Examination of blood.*

Negative.	}	No plasmodia.
		No marked oligocythaemia.

Examination of sputum.

Chiefly tenacious muco-pus, of a disagreeable odor.

Microscopical.

Profusion of	{	Streptococci	>	<i>No tubercle bacilli.</i>
		and		
		Staphylococci.		

Large spore-bearing bacillus, which seems to be the organism described by Lumniczer,¹ found in putrid bronchitis, pure cultures of which produce the disagreeable odor noticeable in sputa of above diseases.

February 13. *Thoracentesis of left pleura* (aspiration).

Examination of pleuritic fluid.

Quantity.....	750.0 cc.	}	Very few red blood cells.
Spec. grav.....	1.021		
React	alkal.	}	Great deal of epithelium, some in condition of fatty degeneration.
Odor	faint		
Color.....	dark straw		
Albumin20% (Esbach)		
Sugar.....			
Globulin.....		}	
No biliary pigments.			

Had severe attack of coughing after aspiration.

February 20. Sputum has repeatedly been examined for tubercle bacilli without result.

February 21. Complains of cough at night, but breathing is much easier after aspiration.

STATUS PRAESENS. February 22. Conjunctivae show slight icterus. Marked pulsation in veins of neck.

Lungs. Some mucous râles over apices of both lungs. Left pleura rapidly refilling. Flatness up to fourth rib, above which Skoda's resonance.

Pericardium. Same.

Abdomen. Distended with fluid. Umbilicus obliterated.

Liver. Ascends to nipple line.

Legs. Anasarca is marked. Skin stretched and glistening over extensor surfaces. Hair follicles on thighs elevated and surrounded by ring of ecchymosis.

The urine gives beautiful "dialy" re- action.	}	Sulphanitic acid in 5% HCl.
		Sodium nitrite.
		Ammonium hydroid.

February 23. Over second left interspace slight loss of resonance; "cog wheel" respiration and fine crepitant râles.

¹ Wiener Medicinische Presse XIX, 666, etc.

Urine shows "kreatinine" reaction for first time to a very marked degree.

February 25. Face somewhat oedematous. Headache.

February 26. Oedema of face disappeared. Anasarca of lower extremities much increased.

II. Paracentesis of Abdomen.

Quantity 1000.0 cc.

Spec. grav 1.019

Albumin 20% (Esbach)

Otherwise identical with first examination.

February 28. Had some epistaxis.

The temperature has been normal right along. Pulse 120.

URINALYSIS.

Date.	Out in 24 hours.	Spec. Grav.	Reaction.	Color.	Ppt.	Odor.	Albumin.	Sugar.	Biliary pigments.	Microscopical.
Feb.	cc.			reddish						Few red blood corpuscles, epithelial cells, copious ppt. of "brick dust" urates.
8	150.0	1.030	acid	turbid.	copious	urinous	trace	none	none	"
9	275.0	1.035	"	"	"	"	"	"	"	"
10	200.0	1.035	"	"	"	"	0.25%	"	"	"
11	240.0	1.032	"	"	"	"	trace	"	"	"
12	250.0	1.025	"	"	"	"	"	trace	"	"
13	240.0	1.030	"	"	"	"	"	none	"	"
14	220.0	1.031	"	"	"	"	0.3%	"	"	"
15	250.0	1.030	"	"	"	"	trace	"	"	"
16	260.0	1.029	"	"	"	"	"	"	"	"
17	200.0	1.032	"	"	"	"	"	trace	"	"
18	350.0	1.030	"	"	"	"	"	none	"	"
19	250.0	1.030	"	"	"	"	"	"	"	"
20	240.0	1.028	"	"	"	"	"	"	"	" + spermatozoa
21	300.0	1.035	"	"	"	"	"	"	"	"
22	200.0	1.032	"	"	"	"	0.2%	"	"	"
23	210.0	1.032	"	"	"	"	trace	"	"	"
24	250.0	1.033	"	"	"	"	"	trace	"	"
25	220.0	1.035	"	"	"	"	"	"	"	"
26	240.0	1.035	"	"	"	"	"	none	"	"
27	300.0	1.033	"	"	"	"	"	"	"	"
28	200.0	1.035	"	"	"	"	"	"	"	"
									"Dialo" Reaction Kreatinine	"

Patient passed from attendant's care February 29th.

On March 10th paracentesis was done at 1.30 P. M., 1600 cc. of liquid being removed. Collapse rapidly supervened, active stimulation was resorted to, but patient died at 5.30 P. M.

No necropsy could be obtained.

REPORT OF A CASE OF EMPYEMA OF FRONTAL SINUS.

DR. MAXWELL E. SILVER, '97.

FROM THE CLINIC OF DR. HARRY FRIEDENWALD.

The following interesting and rare case of empyema of the frontal sinus has recently been under observation at the City Hospital. E. B., male, age 15, was admitted on January 26, '98. He gave a previous history of a fall from a tree in '88, from which he apparently suffered but little immediate discomfort, although a branch of the tree struck him in the right orbital fossa toward the nose. The patient experienced no trouble until two years ago, when a tumor began to appear at the inner canthus. There was no pain excepting headache; there was increased lachrymation and some photophobia. The tumor gradually getting larger, the patient presented himself at the hospital.

Entrance examination.—Patient somewhat scrofulous, tall, and mentally but partially developed, quite anæmic. Temp. 99, pulse 90. He presented a large irregular tumor in the inner portion of the right orbit, reaching down from frontal bone to below caruncle, separated from lachrymal and nasal bones by a deep narrow depression. The tumor was immovable, very hard to the touch, but the skin moved over it freely. It was not specially sensitive to pressure, and there were no outward signs of inflammation, *i. e.* redness, swelling, etc. But there had been considerable deep-seated pain for some time. The eyeball was displaced outwards almost 1 cm., but there was no diplopia.

January 27, '98. After the usual aseptic preparations the patient was anesthetized and Dr. Harry Friedenwald made an incision one inch long through the overlying skin, and with the first blow of a chisel entered a large cavity filled with thickened creamy and odorless pus. This opening was enlarged by removing the projecting bony wall. The frontal sinus was found to have become widely distended downwards and towards the nasal portion. The cavity was irrigated with a mild solution of bichloride of mercury, sinus thoroughly scraped out with sharp spoons, and the rough edges of bone at the mouth of the wound smoothed with a rongeur.

The cavity was then packed with sterilized gauze and dressings were applied.

February 7, '98. Patient dressed for first time, having had no discomfort or rise of temperature since the operation. The packing was taken out, the wound irrigated and more loosely packed with gauze, and a bandage was applied.

March 1, '98. The wound has been dressed every three days and is gradually filling in with granulation tissue from the bottom. The patient feels well. He now has slight diplopia, probably due to cicatricial contraction at upper and inner portion of the orbit. This, we believe, will soon disappear when the bandage is permanently removed.

REPORT OF A CASE OF STAB WOUND OF THE ABDOMEN.

FROM THE CLINIC OF DR. J. W. CHAMBERS.

BY DR. A. COTTON, '96.

Mr. D., aged 46, was brought to the accident ward of the City Hospital on the 18th of January, about 2 P. M. The following history of the case was obtained:

About 1 P. M. of the same day the patient was stabbed by a negro, the instrument used being an ordinary case-knife, ground down to a fine point. After receiving the injury the patient walked about one hundred yards to a room where he was put to bed. A neighboring doctor was called in and after examining the injuries, advised immediate removal to a hospital. The Central police ambulance was called and the patient was brought to the City Hospital. When admitted to the accident ward the patient was very little shocked and showed remarkable nerve.

Examination revealed a mass of intestines and omentum resting on the external surface of the abdomen and a large gaping wound of the right hypochondrium. He was immediately taken to the operating room and anesthetized, while preparations were made for a laparotomy by Dr. Chambers.

The intestines were washed with hot sterilized normal saline solution and wrapped in towels wrung out of the same solution. Further examination revealed a small penetrating wound of the lower edge transverse colon and extending into the mesentery, also a transverse penetrating wound about one and a half inches long of one of the coils of the jejunum. The wounds were closed with a Czerny-Lembert suture of No. 6 silk in an ordinary cambric needle, and strengthened with Dupuytren's continuous suture. The bleeding vessels were tied and the rent in the mesentery closed by a continuous suture. A very interesting condition was then brought to view, viz.: a hernia of the small intestines through a cut about three inches long in the great omentum. The intestines were very much constricted at the opening in the omentum, and had the constriction not been relieved strangulation of the bowels with attendant results would certainly have resulted. The opening in the omentum was enlarged and the intestines returned to the abdominal cavity. The omentum was then closed by a continuous suture and returned to its place. The abdominal wound—a longitudinal cut about one (1) inch to the left of the median line and extending from the level of the umbilicus downward nearly vertically about three (3) inches—was then closed by a single set of silk-worm gut sutures reaching from skin to and including the peritoneum.

The wound of the right hypochondrium was a ragged cut about four inches long to the right of the sternum over the cartilages of the seventh, eighth and ninth ribs. Probing with the finger showed that the knife had penetrated to the *surface* of but had not entered the liver. The wound was cleansed, packed with iodoform gauze and treated as an open wound. Dressings were applied and the patient was placed in bed.

Being profoundly shocked, hot bottles were applied to his body and a hypodermic injection of morphia sulph., gr. $\frac{1}{4}$, and strychnia sulph., gr. $\frac{1}{30}$, was given. In about an hour, the patient being still badly shocked, the morphia was repeated. At 7 P. M. he had completely rallied from shock, and passed a quiet night.

January 19. The patient was feeling comfortable. One grain of

powdered opium was given every four hours. Hot milk, in small quantities, frequently repeated, was the only nourishment allowed. In the evening his condition was good. His pulse and temperature were each 100, and there was no nausea, vomiting, distension of the abdomen or other indication of peritonitis.

January 20. Early in the morning the patient had a natural movement of the bowels. There were no indications of peritonitis and his general condition was good. During the following week his morning temperature was 100°, evening 101°; he had very little pain and his abdomen was not distended, although his bowels did not move during this time.

January 26. The patient was given a soap and water enema, which was very effectual. The wounds were dressed for the first time. The lower abdominal wound had apparently healed by first intention, and all but two of the stitches were removed. The upper wound was clean and granulating nicely. The iodoform packing was removed, the wound irrigated externally with a 1-4000 bichloride solution and a smaller piece of gauze inserted.

January 27. The patient was given his first solid food, consisting of three or four raw oysters. On the following morning he was allowed milk toast and a soft-boiled egg. Solid food was gradually increased, and by the end of the second week the patient was given regular meals. The bowels were moved every other day by soap and water enemata.

The patient did well until the evening of February 2, when his temperature shot up to 102½° and he complained of severe pain in the lower wound. Examination revealed a large stitch abscess in the lower abdominal wound where the two stitches had been left. The sutures were removed and the opening of the abscess enlarged. About one-half a pint of pus was removed, after which the abscess cavity was probed with the finger. It was found that the pus had burrowed into and nearly through the rectus muscle. A counter-opening was made at the lowest point and the abscess cavity was washed with peroxide of hydrogen. On the following day the temperature was normal and the patient was resting comfortably. The wound was dressed daily and healed rapidly.

February 17. The patient was given a saline purge for the first time, and the bowels moved freely.

February 19. Both wounds were reduced to small granulating surfaces, and the patient was allowed to go home.

March 3, Mr. D. was seen at his home. The wounds had entirely healed and he was able to attend to business.

Abstracts.

DR. HARVEY P. JACK, '91, in the *International Journal of Surgery*, has written a paper on "Intestinal Toxemia as a Factor in Retarding the Healing of Wounds." He points out that "intestinal toxemia impairs and destroys vital resistance by its effect on nutrition." And that, in addition to this indirect effect upon the wound, poisons and even micro-organisms may find their way from the infected intestinal canal to the wound, and thus directly interfere with the process of healing.

He recommends, first, that food should be given of such character and in such quantity and frequency that it will be promptly and completely digested and absorbed; second, that charcoal be administered to prevent the absorption of ptomaines; third, that salicylate of bismuth, naphthalin salol and the sulphites be used to inhibit the action of the bacteria; fourth, the administration of calomel, which acts as a laxative, diuretic, and intestinal antiseptic.

As secondary measures, hot air or vapor baths, copious draughts of water and massage are useful.

DR. JULIUS FRIEDENWALD, '90, in the *New York Medical Journal*, gave the results of an experimental study of the action of taka-diastase in various gastric disorders. He says, "The amyolytic action of taka-diastase has been settled beyond all doubt. But, though this has been established by numerous experimenters, the therapeutic indications for its use are still ill-defined, for no one has as yet tested the action of

taka-diastase upon digestion within the stomach itself." He then gives the details of his experiments, and reaches the following conclusions:

"1. That taka-diastase exerts no influence under normal conditions upon gastric digestion nor upon cases of nervous dyspepsia with normal motor and secretory functions.

"2. That in cases of motor disturbances of the stomach with normal secretory functions, such as atony, taka-diastase increases the motor action without in any way influencing the secretory function or the digestion of starches.

"3. That in cases of subacidity taka-diastase acts differently, according to whether there is a catarrh or a nervous dyspepsia. In nervous cases it has no effect whatever upon digestion, while in cases of catarrh it appears to have a tendency to increase the flow of acid and promote the digestion of starches.

"4. That taka-diastase exerts its most favorable influence in cases of superacidity. It not only promotes the digestion of starches in these cases, but diminishes the excess of acid and increases the motor function.

"5. That taka-diastase in a great measure replaces the saliva when this secretion is diminished or absent. It then not only digests the starches in the stomach, but serves the other function of the saliva in stimulating the gastric secretion and therefore promoting the proteid digestion."

DR. W. E. FITCH, '91, in the *Georgia Journal of Medicine and Surgery*, has a voluminous paper on the results of tight lacing. The following are his conclusions:

1. The normal breathing of woman is like that of man—abdominal; tight lacing changes the types to costal.¹

2. The pelvic organs normally make a considerable excursion with each respiration.² Tight lacing in the upright position checks this motion almost entirely.

¹ Wilberforce Smith, Brit. Med. Jour., Oct. 11, 1890.

² Kellogg and Mary Putnam Jacobi.

3. Sitting or leaning forward lessens intra-abdominal pressure.¹ Tight lacing in these positions greatly increases intra-abdominal pressure.²

4. The uterus is displaced downward by tight lacing from one to two and a half inches. The pelvic floor is bulged downward and the circulation rendered sluggish.

5. Uterine development is greatest from the twelfth to the sixteenth year. Tight lacing is usually commenced at this the period of the beginning of uterine development.

DR. BRACK, '95, reports two cases of fingers amputated by machinery in which nosophen was used as a dressing instead of iodoform. The results were in every way most satisfactory. As a primary dressing a wet bichloride dressing was used and on the third day dressing of nosophen applied. In both cases the dressings were not disturbed again for five days, when the wound was found to be granulating nicely. There had been but very little discharge and the dressings were quite dry. The entire absence of odor, the cleanliness and the rapidity with which healing and repair take place recommend the preparation very highly.

¹ Dikman.

² Schatz, Archives of Gynæcology, III, 58, IV, 1893.

³ The Corset Question, Kellogg, N. Y. Med. Jour., Nov., 1887.

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THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

DIAGNOSIS OF EARLY PREGNANCY.

The importance of recognizing the gravid uterus and distinguishing it from other pelvic tumors is much greater now that operations for the removal of pelvic disease has become an everyday occurrence, than it was in the days when operative interference was less common. The difficulties of the diagnosis have been much exaggerated by the teaching of obstetricians who are familiar only with the gravid uterus near full term. All that is necessary is to outline the body of the uterus as in an ordinary bi-manual examination, and to determine that the body is enlarged and cystic. Practically speaking, every cystic uterus is a pregnant uterus. By this method, pregnancy that has advanced to the eighth week can be determined in almost every instance, and not infrequently a gestation that has not advanced beyond the sixth or seventh week can be clearly recognized. There is no other pelvic tumor of equal size that can be recognized by touch with as much certainty as an eight weeks' pregnant uterus.

W. S. G.

TO THE ALUMNI.

We wish every alumnus of the College to receive the JOURNAL, because we think it will be useful to them and because we think each one will take pleasure in hearing from his old college friends through

its pages. So, when you send in your name to the business manager send also a letter telling us how you and the other "boys" in your neighborhood are getting along. We would be glad to have a hundred letters like the one by Dr. Priddy published in this number.

In the meantime, it should not be forgotten that the JOURNAL is not subsidized by a liberal patron, nor fostered by a high protective tariff. It must pay its own way.

Our list of subscribers is increasing rapidly; see to it that you are one to help shove this good thing along.

ANNUAL MEETING OF THE ALUMNI ASSOCIATION.

The regular annual meeting of the Association was held at the Eutaw House, April 13, 1898, the President, Dr. Harry Freidenwald, in the chair.

Dr. Gardner, as chairman of the prize essay committee, reported that no essays had been submitted, and moved that in future no prize should be offered. The motion was unanimously carried.

The following officers were elected for the ensuing year: President, W. P. Spratling, New York; first vice-president, S. H. Allen, Utah; second vice-president, H. S. Jarrett, Maryland; treasurer, C. E. Brack, Maryland; secretary, W. W. Frames, Maryland; assistant secretary, H. Westphal, '98, New York; executive committee, Harry Friedenwald, '86, chairman, J. M. Scanland, '97, and Wm. Gombel, '77.

On motion, a permanent publication committee, consisting of the president, treasurer, secretary, and chairman of the executive committee, was established.

The orator of the evening, W. P. Spratling, being absent, the annual oration was dispensed with.

The Association then adjourned to the banquet hall.

The out-of-town alumni who attended the banquet were R. Sumpter Griffith, '86, Virginia; L. F. Ankrum, '86, Pennsylvania; M. A. Bailey, '93, Conn.; G. B. Jarvis, '92, New York; H. B. McDonnell,

'88, Maryland; H. S. Jarrett, '84, Maryland; T. H. Brayshaw, '85, Maryland; R. J. T. Barber, '86, Delaware; R. F. Gundry, '88, Maryland; G. C. Brooks, '84, North Carolina.

Personal Notes.

DR. GEO. H. P. COLE, '79, has retired from practice and is a successful banker at Hendersonville, N. C.

DR. D. C. HUGHES, '93, spent two years in Chicago after graduation. He is now at Findlay, Ohio, where he is president of the Hospital Clinical Society, surgeon to the City Hospital, and secretary to the Hancock County Medical Society.

DR. A. C. LOPER, '96, after graduating, passed the State Board examination, then spent some months in the City Hospital on Blackwell's Island, and the Maternity, 17th street, New York, and is now located at Greenport, N. Y.

DR. J. W. KIDD, '84, is practicing at Booneville, W. Va. He has for two years been health officer for Braxton Co., and has been one term in the State Legislature.

DR. E. H. BOWLING, '91, of Luster, N. C., reports that he has all the practice that he can attend to.

DR. GEO. L. BROADRUP, '91, has been located at Cumberland, Md., for the past two years.

DR. W. S. ALEXANDER, '93, is located at Oxford, Ohio. He is president of the Butler Co. Medical Society, is surgeon to the C. H. & I. R. R., and is making about \$6000 per year out of his practice.

DR. C. C. CORNER, '86, is located at Carthage, Texas. He is the local surgeon of the Texas, Sabine and Northwestern Railroad, and is making a specialty of the eye, ear, nose and throat.

DR. M. L. CURRIE, '88, has a fine general practice, and has done some very successful surgery at Riley, Ga.

DR. H. W. CRONIN, '93, is located at Millbury, Mass. He is a member of the "Massachusetts Medical Association," the "Massachusetts Association of Boards of Health," and chairman of the local "Board of Health."

DR. C. W. SPANGLER, '83, is a member of the State Board of Health of West Virginia.

DR. GUY C. M. GODFREY, '92, son of Captain E. L. Godfrey, one of the survivors of the Custer massacre, is surgeon in one of the infantry regiments of the regular army now at Santiago de Cuba.

DR. SYDNEY O. HEISKEL, '82, is assistant surgeon on board the auxiliary cruiser Dixie.

DR. W. E. LOWREY, '92, is practicing in the City of Mexico.

DR. R. G. O'HARA, '85, at Bedford City, Va., is Secretary of the Board of Health and Physician to the Randolph-Macon Academy.

DR. THOMAS R. MARSHALL, '93, is Professor of Principles of Dentistry, Oral Surgery and Special Anatomy of the Head at the Medical College of Virginia, Richmond.

DR. FRANK J. HALL, '97, is assistant at the Charitable Eye and Ear Infirmary at Dallas, Texas.

DR. A. B. BENNETT, '81, DR. CHAS. B. MCCOY, '82, and DR. JESSE G. PALMER are all at Opelika, Ala.

DR. W. C. MCCURDY, '74, has a large and lucrative practice at Madonna, Md.

DR. C. EMMERT STUART, '86, who is located in Pittsburgh, had a very severe attack of typhoid fever in April.

DR. J. G. SIMMONS, '91, is Physician to the German Odd Fellows Home and Orphan Asylum at Westchester, New York.

DR. GEO. H. PETERS, '91, has taken a course in Homeopathy and removed to Washington, D. C.

DR. H. V. DAVIS, '94, is making a success of his practice at North Branch, N. J.

DR. G. E. DAY, '94, is located at Millville, N. J. He is making a specialty of diseases of the eye.

DR. E. VAN HOOD, '84, who was Resident Physician at the City Hospital in '84 and '85, is practicing in Ocala, Fla.

DR. J. E. JEWELL, '81, is located at Moran, Kan. He is a member of the Board of Pension Examiners, Coroner and Health Officer for the county. In other words the doctor is strictly in it.

DR. W. J. A. O'HARA, '93, is one of the lecturers in the Bridgeport Hospital Training School of Bridgeport, Conn.

DR. E. A. GIBBS, '81, is located in Washington, D. C. He is Medical Examiner to the U. S. Pension Bureau and Lecturer on Bacteriology at the Georgetown University Medical College.

DR. EUGENE G. CARPENTER, '84, has been elected recently Superintendent of "The Ohio State Asylum for the Insane," at Columbus, Ohio.

DR. T. F. LANHAM, '80, is a member of the State Board of Health of W. Va. He is located at Newburg.

DR. FRANK D. KINSLEY, '82, is an Ex-president of the Clinton Co. Medical Society and President of the Medical Association of Northern N. Y.

DR. J. L. CHRISTIAN, '90, is practicing at Lopez, Pa. He is local surgeon to the Lehigh Valley Railroad.

DR. MARSHALL H. BAILEY, '92, is located in Boston, Mass. He has a private sanitarium for the treatment of diseases of women, in which he is doing some excellent work. He will be remembered as having left a fine record in work of the same line when resident at the City Hospital.

He is Assistant Visiting Physician to Harvard University, Lecturer on Physiology at Dr. Sargent's Normal School and at the Harvard Summer School; pathologist to St. Elizabeth's Hospital and to the Woman's Charity Club Hospital.

In other years the doctor strove to see people as they wished to appear; he now strives to see them as they are.

DR. CHAS. A. RAY, '87, located at Winefrede, W. Va. For the past ten years he has been surgeon to the Winefrede Coal Co. The doctor spent several weeks in the city in April and May doing post-graduate work. In the next number of the JOURNAL we expect to publish a paper on Neuritis by him. He has sent the JOURNAL a reprint in which he gives an account of an Epidemic of Typhoid, including eighty-one cases with only three deaths. That is certainly an excellent record.

DR. N. T. CARSWELL, '86, recently returned from a year spent in study in Europe. When first discovered he was holding up the railing in front of the college and a sense of perfect contentment beamed from his countenance. His greeting was "Habe die Ehre" in an abdominal Viennese that would have done credit to a native Wirth. The German fairly rolled out, but he suddenly stopped and said in fairly good English, which he is still able to speak, "This is the first chew I have had for a year."

The doctor spent most of his time on internal medicine and will locate in Macon, Ga.

The members of the Lime Kiln Club which flourished in the winter of '86 and '87 are widely scattered. The two residents at the City Hospital are still in Baltimore; "Elder Toots," a young man of the name of Phillips, when last heard from was in St. Louis and had grown into a mighty professor; "Pickles Smith," otherwise White, is at his native place, Montezuma, N. Y.; Newsome is practicing at Ocala, Fla.; Johnson at Micanopy, Fla., and Griffith at Middleburg, Fla. Florida has more than her share of these choice spirits.

DR. JOHN B. BOUCHER, '94, of Hartford, Conn., who has for some time been Surgeon of the Electric Railway of that city, has recently been appointed Surgeon to St. Francis Hospital.

DR. J. A. KILBOURN, '97, reports that he has a good practice at Hartford, Conn.

DR. W. M. BOONE, '91, has a flourishing practice at Highland, Kan.

DR. J. B. PAYNE, '96, who is practicing at Clarksburg, W. Va., was in Baltimore recently.

DR. E. H. EWING, '97, is assisting Dr. W. P. Faxon in private practice at Stoughton, Mass.

DR. FRANK E. WAGNER is Assistant Surgeon in the Maryland Naval Reserves, and along with the other officers and men of that organization has been mustered into the United States service.

DR. J. PERCY WADE, '91, succeeded Dr. Rohe as Superintendent of Spring Grove Asylum and still holds that position.

DR. W. WAYLAND FRAMES, '92, after spending the greater part of a year in New York at the various Throat Clinics, has opened an office at 922 Madison Ave. and is devoting himself to nose and throat work.

KEYSVILLE, VA., April 11, 1898.

Dear Dr. Gardner.—I was delighted to receive a copy of the JOURNAL of Alumni Association of P. & S. It indeed fills a long-felt want as a means of hearing from our classmates, and besides, the articles in the initial number are of high grade. I gladly enclose check for one year's subscription. We have in the ranks of our profession in the Old Dominion many P. & S. alumni, who are well sustaining the reputation of our Alma Mater. Of the twelve regular members of our State Board of Medical Examiners, three are P. & S. men—Drs. R. M. Slaughter, class '79, R. S. Martin, '83, and myself, '86. Dr. Slaughter as a writer and practitioner ranks with the highest. Dr. Martin was house surgeon at Woman's Hospital, 1884-5, and since locating in Virginia has been making a specialty of gynecological and abdominal work. He is surgeon in charge of Mothers' Home, his private sanitarium, at Stuart, Va., and is winning fame and fortune for himself. Drs. C. W. Pritchett, Keeling's, Va., G. P. Moore, Cape Charles, Va., H. W. Dew, Lynchburg, Va., all of '86, are leaders in their localities. Dr. N. H. Neblett, of '84, represented Lunenburg county in the last Legislature, but died in the middle of his term. Dr. L. S. Mason, '76, is at Clover, Va., doing well. Dr. B. C. Keister, '82, is at South Boston, Va.; he is succeeding in every way. Dr. Chas. W. Jones, '94, is at Red House, Charlotte county, Va., and is very dear to the hearts of his people. Dr. Julian H. Abbett, '92, is a successful physician and an honored citizen of Appomattox county. Dr. S. A. Hughes, '91, is building up a good practice in Danville.

I have been practicing here since graduating in '86; have been for five years a member of the State Board of Medical Examiners, vice-president Virginia Medical Society and a member of the Virginia Legislature.

I wish the JOURNAL great success. I wish you would write up the class of '86 in, say, your June number. Ask all members to send an account of themselves by that time.

Truly yours,

A. S. PRIDDY.

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Vol. I

No. 3

OCTOBER, 1898

PUBLISHED AT
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Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

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Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. B., M. D.

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CATONSVILLE, MD.

REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Personal Notes.

DR. M. E. SILVER, '97, has located in Sioux City, Iowa.

DR. JAS. A. BAILEY, '95, has left Madison, N. J., and located in Baltimore.

DR. J. A. BLANCHARD, '97, was appointed Assistant Surgeon of Volunteers.

DR. J. THOMPSEN HUME has removed from Hinton, W. Va., to Newport News, Va.

DR. A. P. BUTTE, '95, of Moorefield, W. Va., brought a patient to the City Hospital in July.

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Personal Notes.

DR. C. PERCY KEMP, '95, who is located on Kent Island, Md., was recently in the city on professional business.

DR. J. M. WALLS, '96, is located at Naples, Texas. There in the central cotton belt his practice yields him an income of two thousand dollars annually.

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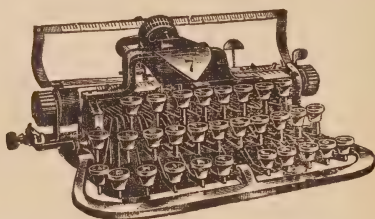
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COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

VACCINATION, REVACCINATION.*

BY DR. WILLIAM J. TODD, '89.

This is a subject with which we are so familiar that I am afraid both we, the physicians, and we, the people, whose lives and health are to be guarded, have of late treated it with neglect and perhaps with contempt.

To-day we know little or nothing of the horrors of smallpox, except that which we have learned from history. Very few of the younger generation of physicians have seen a case of smallpox, and few of the older men have experienced an epidemic, for which fact we owe many thanks to the discovery of Jenner.

This discovery and the application of it, the great benefits that have accrued to mankind from it, not only in the saving of life, but in the increase of the average length of life, the decrease of impaired constitutions, of partial or total blindness and disfigurement of features—all this, which previous to Jenner's day resulted from that offensive, most loathsome and most contagious of all diseases—smallpox.

If medicine had made no other discovery, made no other advancement during the past century, medicine by this one act alone would

* Read before the Maryland Public Health Association, May 11 and 12, 1898.

have covered herself with a crown of glory as bright and as lasting as the sun.

I quote at length from Dr. Moore's article on "Smallpox" in the *Twentieth Century Practice*:

"In Europe smallpox was one of the most widely distributed, most frequent and most destructive of pestilences up to the introduction of vaccination.

"Before the introduction of vaccination the annual mortality from smallpox in England and Wales alone was at the rate of 3000 deaths in every 1,000,000 of the population; this, according to the census of 1894, would correspond to a loss of some 87,000 lives per annum.

"In 1890 smallpox caused only fifteen deaths in England, and the average annual number of deaths from this disease in the ten years 1881 to 1890, inclusive, was one-seventieth part only of the death rate of prevaccination times.

"Lord Macaulay, writing of the death of Queen Mary in 1694, thus describes the ravages of smallpox: 'That disease, over which science has since achieved a succession of glorious and beneficent victories, was then the most terrible of all ministers of death. The havoc of the plague had been far more rapid, but the plague had visited our shores only once or twice within living memory, and the smallpox was always present, filling the churchyards with corpses, tormenting with constant fears all whom it had not yet stricken, leaving on those whose lives it spared the hideous traces of its power, turning the babe into a changeling at which the mother shuddered, and making the eyes and cheeks of the betrothed maiden objects of horror to the lover.'"

My experience and the experience of other physicians with whom I have compared notes leads me to fear the pendulum has swung to the other extreme in our Maryland, that we are neglecting this most successful preventive of disease. I find upon reviewing the literature on this subject that the cause of the recent outbreaks of smallpox in this country and other places has been attributed to neglect and carelessness in not vaccinating properly. No sane man with the evidence before him will deny the value of vaccination.

I quote from the Maryland laws relating to the public health, as compiled by Dr. James A. Stuart:

"1872, Chapter 257, Section 6.—It shall be the duty of every parent and guardian to have his or her child vaccinated within twelve months after its birth, if it shall be in proper condition, or as soon thereafter as practicable, etc.

"Section 7. No teacher in any school shall receive into such school any person or a scholar until such person shall produce the certificate of some regular practicing physician that such applicant for admission into the school has been duly vaccinated," etc.

The law regarding the vaccination of children within the first year of their life is usually ignored. Children are not vaccinated until the school age, and only then because, as we see above, the teacher must not admit them to the school until a certificate from a physician has been secured stating the child therein named has been duly vaccinated. I have been credibly informed that even this precaution is disregarded in some places. (Dr. S. J. Fort's paper, November 19, 1897, Maryland Public Health Association.)

The teacher does not know, nor inquire, perhaps, if the particular child has been properly protected from smallpox; in fact, she cannot refuse the certificate if she should know otherwise.

Colonel Charles B. Rodgers of the Baltimore county schools tells me he has frequently felt sure of the insufficiency of the protection of a vaccination in some school children, but was powerless to act, as a physician's certificate was on file with the teacher.

My attention was called recently to this subject by the following cases:

Elmer S. had been transferred from one county school to a second. He did not bring the physician's certificate of vaccination with him, which he had deposited at the school last attended. He came to me for my signature to a second blank, which I refused, as I developed, upon examination, the following history:

Elmer applied some three years ago to a physician for vaccination, as he was about to enter the public school, and his physician vaccinated him and signed a certificate at once. The vaccination did not take, yet the letter of the law had been complied with.

The teacher was satisfied; she had the physician's certificate that the boy had been duly vaccinated to protect her.

I ask, was the spirit of the law complied with? The boy certainly was not protected.

Another case in point: F., D., P. and S., aged six, eight, ten and twelve years respectively, members of the same family. F., the youngest, was old enough to enter the public schools and must be vaccinated, which I did. I found upon inquiry that D. and P. had been vaccinated the year before. S. had been vaccinated three different times. All were attending school and having the necessary certificates. Thinking it best, I revaccinated, and all suffered the usual symptoms of an original vaccination.

With these children the physician performing the vaccinations signed the certificates before the children left his office, not waiting until he was sure beyond doubt the result was a success.

The immunity in the oldest child by the first vaccination, if a success, might have been exhausted and revaccination necessary, but my impression at the time was that the different vaccinations were not successful.

Another source of error is the habit of physicians to examine the arms of children who have been vaccinated, from five to ten years and more, and pass them, when the test of revaccination should be made.

"If thorough vaccination and revaccination of whole communities were possible, smallpox would almost disappear."—"The Practice of Medicine," Wood and Fitz, 1897, p. 116.

Rohé, in his "Text-Book of Hygiene" (edition 1894, p. 342), writes: "In order to secure permanent protection against smallpox, revaccination should be performed after a certain interval. Some place the period at which this second vaccination should be done at five years, while others allow a longer interval—seven, eight or ten years."

Our Dr. Osler records in his work on "Practice," p. 51, an epidemic of smallpox as late as 1885. Smallpox had been prevalent in Montreal in 1870 and 1875. The city was free from it until 1885. During these ten years the people opposed and neglected the operation, so that the younger population was unprotected. The epidemic of 1885

started February 28 from an imported case from Chicago, a conductor of a Pullman car. From this case the disease spread to such an extent that within nine months 3164 persons died from smallpox in Montreal, the population at that time numbering some 200,000.

"Revaccination should be performed between the tenth and fifteenth year and whenever smallpox is epidemic. The susceptibility to revaccination is curiously variable, and when smallpox is prevalent it is not well, if unsuccessful, to be content with a single attempt" (Osler, p. 65).

Dr. John Campbell, Medical Officer of Health of Gloucester, England, writes in the London *Lancet* of April, 1897:

"The population of Gloucester was 41,000, of whom very few adults had ever been revaccinated, and since the guardians ten years ago ceased to enforce the acts the great majority of the children, forming probably nearly one-fourth of the inhabitants, had remained entirely unprotected. Indeed, the anti-vaccinationists boasted that Gloucester was the least vaccinated town in England and had enjoyed immunity from smallpox for twenty years. The first cases occurred in June, 1895. In January, 1896, forty-one cases were reported; February, 150; March, 518; April, 783; May, 367; June, 112; July, 23—total, 1994.

"Seven hundred and forty-two cases were treated in hospitals; the rest were treated at their homes.

"There were 710 cases under ten years of age, of whom twenty-three had been vaccinated and 687 had not been vaccinated. Of the vaccinated, none died; of the unvaccinated 278 died.

"Between the ages of ten and twenty years there were 309 cases. Of this number 260 were vaccinated in infancy, of whom nine died; forty-nine were unvaccinated, of whom thirteen died.

"There were 925 cases above twenty years of age. Eight hundred and eighty-nine were vaccinated, with ninety-nine deaths; thirty-six were unvaccinated, with fifteen deaths, thirty-five cases occurring in persons who were said to have been vaccinated in infancy, but who show no marks; they were practically unprotected and fifteen of them died."

The elder Flint (6th edition, 1886, p. 1046) wrote regarding revaccination: "It is evidently better that the period should be needlessly short than too long. With our present knowledge the propriety, if not importance, of revaccination every five years is to be advocated. In cases of known exposure, or when smallpox prevails as an epidemic, it is proper to vaccinate without regard to previous vaccination. Revaccination, in fact, is always proper as the readiest and safest test of unsusceptibility to smallpox."

"Revaccination is essential at not longer periods than eight or ten years. . . . Whenever any person is exposed to an epidemic of smallpox revaccination should be insisted upon. . . . In cases of failure to 'take' there should be repetition of the vaccination almost indefinitely if there be positive exposure to smallpox."—"Practice of Medicine," Wood and Fitz, 1897, p. 118.

In closing this paper I would urge upon parent and guardian not only is vaccination, but revaccination, necessary. Can you doubt it when you have such evidence as Dr. Campbell of Gloucester?

To the teacher: As the law now reads you cannot do more than have a child duly vaccinated, but urge upon him the value of a revaccination, and during an epidemic of smallpox frequent vaccinations. For yourself, be revaccinated frequently; you owe this to yourself for your own protection.

I would suggest to the county commissioners the money spent for vaccination and revaccination is not an expense, but an investment that will pay a large percentage of profit in the future health of your county.

I will again urge my measure of last year. Appoint a physician to have charge of the health and sanitation of certain specified schools, to visit them daily, vaccinate and revaccinate pupils and teachers when he thinks it necessary, dismiss sick children and readmit the convalescent.

The commissioners should furnish the best vaccine virus and pay the physician a good salary for his work.

We physicians should give more attention to this operation, procuring fresh virus, use the necessary precautions to prevent a mixed

inoculation, postponing the signing of school certificates until satisfied the operation has been a success, performing revaccination if necessary to satisfy ourselves.

In the families we attend advise the revaccination of all children when they reach the age of ten years.

THE SIGNIFICANCE OF CERTAIN EYE AFFECTIONS IN THEIR RELATION TO DISEASES OF THE BRAIN AND SPINAL CORD.*

BY DR. HARRY FRIEDENWALD, '86.

OPTIC NEURITIS.

Optic neuritis is found in various cerebral diseases—abscess of the brain, hydatids and softening of the brain, more often in meningitis, but most frequently in encephalic tumor. It has also been found, but very rarely, in acute diseases of the spinal cord. Its frequent occurrence in various general constitutional diseases, as well as from local causes, lessens its pathognomonic value. It is usually double. When unilateral it is due to local causes; but this rule is not invariable.

Ophthalmologists have for many years followed Graefe in distinguishing between two forms of optic neuritis: the descending, in which the inflammation extends from the brain down the nerve and finally shows itself at the papilla, and the ascending or choked variety, in which the cedema and inflammation take their rise in the distal end of the nerve. These varieties often merge insensibly one into the other; their later stages are often indistinguishable. These reasons, added to the fact that the division rests on hypothetical grounds about which there is much diversity of opinion, have led Gowers to base a division upon the degrees of intensity of the visible changes in the optic discs. He therefore describes the slight, the moderate, and the intense forms.

The relation of optic neuritis to meningitis depends clearly upon

* This paper is an abstract of one read before the Baltimore Neurological Society.

continuity of structure, the inflammation passing from the meninges down the sheath of the nerve. For this reason the optic nerve is affected more commonly, earlier and more intensely when the meningeal inflammation is at the base than when on the convexity; in the latter case neuritis is indeed usually absent. The absence of optic nerve changes in many cases even of basilar meningitis (of all varieties) should guard us from overestimating the value of negative ophthalmoscopic findings in suspected meningeal disease. Considerable difference, however, marks the different varieties. Thus in tubercular meningitis (slight or moderate) well-defined neuritis is seen in half the cases, and slight changes in many more. In syphilitic meningitis the optic neuritis is apt to be intense; thus in the former variety the picture agrees more often with Graefe's descending neuritis, in the latter with the ascending form.

In epidemic cerebral meningitis optic neuritis is common in cases lasting more than five days (Gowers), but in this disease purulent irido-choroiditis is the more usual complication.

In simple meningitis, as in the former varieties, we may have neuritis varying from slight hyperemia up to an intense form, but the discs rarely become very prominent, and hemorrhages or exudates are rare upon the discs.

Optic neuritis is a frequent symptom of encephalic tumors, occurring in about four-fifths or more of the cases. Its occurrence does not depend upon either the seat, the variety or the size of the tumor, nor upon its origin in the meninges or in the brain substance. "It is certainly less frequent when the growth is in the membranes over the convexity and merely compresses the brain, than when the cerebral tissue is actually invaded" (Gowers). It may be present in very small tumors and absent in large ones. The characteristic variety of optic neuritis found in these cases is that known as the "choked discs," with great prominence of the papilla, congestion and tortuosity of the veins and narrow arteries. It develops rapidly, and may reach such intensity as to entirely change the appearance of the papilla. It may occur at any stage of development of the tumor, early or late, run its course slowly or rapidly, ending in atrophy, while the tumor

continues to develop. "Often, however, the occurrence of the neuritis coincides with an obvious increase in the other symptoms of the growth, and probably always indicates progress of the disease" (Gowers).

Many hypotheses have been offered to explain the connection between the neuritis and the tumor, but none is entirely satisfactory. Graefe attributed it to venous congestion and stasis resulting from intracranial pressure upon the cavernous sinus, and the term "Stauungspapilla" or "choked discs" was therefore selected. But this theory is partially disproved by finding free anastomosis between the ophthalmic and facial veins and by the observation of closure of the cavernous sinus without neuritis. After Schwalbe discovered the communication between the sub-vaginal and sub-dural spaces, and the former was found usually (but not invariably) dilated in cerebral tumor, Schmidt and Manz suggested that the collection of fluid in the sheath of the optic nerve produced a lymph stasis, especially in the region of the lamina cribrosa. The œdema here caused compression of the central vessels and venous stasis and swelling of the papilla; choked disc resulted. This theory has been variously attacked by those who even admit it as a factor, but not as the sole factor, in producing neuritis. Leber suggests that pathogenic material contained in the distending fluid produces irritation and inflammation. But the question is made still more complex by the fact that no symptoms of increased intracranial pressure may accompany this form of optic neuritis, and that it may accompany other conditions, such as anæmia, without any intracranial trouble; besides this, it is very rarely found in hydrocephalus, where the increase of intracranial pressure is most pronounced. Gowers points out that "the great distension of veins and narrowing of arteries occur when the inflammation has reached a certain degree of intensity." This points to the neuritic process in the papilla as causing the strangulation by pressure on the vessels. This view is entirely borne out by pathological investigation. He has never been able to discover any evidence of constriction of the vessels in the sclerotic ring or behind it. "Their calibre here is always uniform." "It is always in front of the sclerotic,

in the substance of the swollen papilla, that the vessels present conspicuous constriction, are pressed upon and have their walls thickened by new tissue."

His conclusions are that "in cases of cerebral tumor evidence of descending inflammation may be traced in sheath or nerve much more commonly than current statements suggest, while in cases of meningitis the evidence of such descending inflammation is almost invariable. That the resulting papillitis may be, and remain, slight, or may become intense and present the appearance of mechanical congestion. The causes of this difference we do not yet know."

In considering cases of neuritis it is especially necessary to remember the fact that they may arise from other than encephalic causes; the accompanying symptoms may even point to tumor and yet a further course almost exclude this. I have seen a case at intervals during the past ten or twelve years, in which two attacks of neuritis arose after an interval of many years and passed off, but slightly affecting the vision. The patient, a lady, was about 35 years when the trouble began, and during the second attack had violent headaches with attacks of slight unconsciousness, etc.; the symptoms again subsided under iodide treatment, although a specific basis was excluded.

OPTIC ATROPHY.

Optic atrophy is often divided into two forms: first, that resulting from neuritis, the neuritic form; and secondly, the non-inflammatory or simple. In the former the papilla is white and opaque, may be slightly convex, the arteries are fine and accompanied by white streaks, and the veins are narrow but tortuous; the margin of the disc is irregular. In the second form the papilla is white or grayish white, transparent, showing the lamina cribrosa sharply outlined by a regular border, and though finer vessels are absent on the disc, the larger ones often retain their normal calibre. All varieties between these extremes may be present. The division of simple atrophy into primary and secondary is very important. In primary atrophy loss of sight coincides with the onset and progress of the visible changes in the papilla, while in secondary atrophy loss of sight may precede

for a long time the changes in the papilla. However, when the atrophy is thoroughly developed in either case they are not to be distinguished by their appearance.

The important type of primary atrophy is that found in disease of the spinal cord, especially in locomotor ataxia. The disc is grayish white, and the condition is due to a primary atrophy of the nerve fibres. As is well known, the optic nerve changes may long antedate any spinal symptoms. It is slow in its progress, but always leads to complete blindness and is always bilateral. Optic nerve atrophy is associated with spinal disease in about half the cases of the latter. It occurs, however, in a large number of cases without any spinal affection, even though the case be followed for many years. The disturbance of vision in these cases is more or less characteristic. In a few cases there is concentric contraction of the fields for white and for color, each keeping pace with the others; in other cases the fields for colors are rapidly contracted, but singly, green, red and blue being lost before the field for white is much affected. But in most cases there are sector-like losses of peripheral vision, both for white and for colors (in any part of field, often symmetrical), and this may be combined with a concentric narrowing. As a result of this, central vision, though impaired, often remains fair until the color-blindness is total, or the apex of a sector defect reaches the point of fixation.

The connection between the optic nerve atrophy and the spinal disease is not yet definitely explained, but it appears that the two are independent of each other and associated symptoms of a profound disorder of the nervous system.

In disseminated sclerosis complete atrophy is rare (3 per cent), but partial atrophy more frequent (19 per cent). Central and peripheral scotomata are frequent, but defects of the field such as described for the preceding form are rare. The affection may be unilateral; vision varies, sometimes better, then again worse. In this case the disease begins in the finer connective tissue septa, then attacks the greater ones, and thus the atrophy of the nerve fibres is a secondary result. Slight neuritis sometimes occurs, which then passes into atrophy, but the important fact is that vision does not suffer very much in this disease.

In general paresis atrophy occurs in a small percentage of cases (6 to 8 per cent) and is usually a late symptom. In this case likewise central scotoma is sometimes found.

Secondary atrophies depend upon lesions of the optic nerve behind the entrance of the retinal blood-vessels. A typical case is the following: A young man fell, was unconscious and delirious for a day and a half. There was no injury to the eye, but signs of basal fracture. When he recovered consciousness the left eye found to be totally blind. A few days later the ophthalmoscope showed the papilla to be perfectly normal. In less than two months he was seen again and there was typical white atrophy. Tumors, aneurisms, etc., causing pressure upon the optic nerve or tracts have similar results. In hydrocephalus pressure is exerted by the distended third ventricle and atrophy results. Meningitis may likewise produce this form of atrophy (as well as the neuritic form). It is most commonly due to disease around the optic foramen.

Neuritic atrophy is the result of neuritis and need not be further considered.

Before leaving this subject I should again like to lay stress upon the importance of examination of the field of vision. The color of the discs varies greatly in health and may show decided pallor in retro-bulbar neuritis, especially in the toxic form, and the only reliable guide in the diagnosis of the early stages of atrophy is the careful examination of the fields for white, blue, red and green and for scotomata.

HEMIOPIA.

The next subject I should like to consider is hemiopia. We may omit considering the rare bi-temporal and the still rarer bi-nasal forms depending upon lesions of the chiasm, except to state that these cases are usually progressive and often lead into atrophy of one or both nerves. These cases are at times distinguished with difficulty from the tabetic atrophies with symmetrical defects.

Homonymous hemiopia covers not only those cases in which the right or the left half of both fields is lost, but also where a large portion or small defect is present, symmetrical in shape and position.

The dividing line sometimes passes directly through the centre, frequently leaving a small area on the affected side of the point of fixation. The dividing line is sometimes sharp, at others it is formed by a narrow area of indistinct vision. It is sometimes vertical, sometimes slanting, but these variations are not characteristic of any special lesion. A partial defect is more likely to be due to lesion in or near the cortex where the nerve fibres separate, and not in the tract where they are bunched together, but this rule is not fixed. We find in rare cases loss of color sensation in one-half of the field without affection of the field for white. This form, known as hemi-achromatopsia, depends upon a cortical lesion, and thus may assist in locating the disease.

NEURITIS.

BY DR. CHARLES A. RAY, '87.

As its name implies, neuritis is an inflammatory affection of a nerve trunk or nerve branches. Simple when it affects a single nerve trunk or its branches, multiple when it affects different nerve trunks and their branches throughout the body or extremities. It may be acute, sub-acute, or chronic.

Causes: traumatisms, exposure to cold, infectious diseases; metallic poisons, such as arsenic and lead, are other causes. Alcohol in its various forms is a potent factor in the etiology of neuritis. Of the thirteen cases which have come under my observation within the past five years, two were due to injury, three were due to rheumatic influences, five being brought on by exposure to cold; two cases of multiple neuritis were sequels of diphtheria, and one of simple neuritis followed typhoid fever. To classify as to locality, the sciatic nerve was affected in six cases, the facial in two cases, the musculospiral in one case, causing the characteristic wrist-drop of lead poisoning, but in this case the result of a night-watchman lying on the ground with his arm for a pillow, and the remaining three cases of multiple neuritis due to causes above stated.

Clinical history.—The clinical symptoms of neuritis are pain, im-

pairment of the different sensations, motor paralysis, electrical changes, trophic changes in the skin by which it assumes a glossy or copper-colored appearance, and sometimes œdema of the extremities. The disease is usually preceded by a feeling of malaise, chilliness and fever. The pain may be so slight as to be scarcely noticeable, but, as a rule, it is severe, causing very great suffering, being worse at night than in daytime. The motor and sensory symptoms vary extremely in different cases, according to location and character of nerve affected; neuritis of the optic nerve leading to changes of vision, of the auditory to deafness, loud noises and disturbances of equilibrium, of the motor-oculi to strabismus and pupillary changes. Neuritis of the intracranial nerves is seldom by itself, but is usually associated with intracranial diseases and multiple neuritis. The sense of touch and the sense of pain are usually most impaired. The sense of temperature is less frequently affected, although in one of my cases the man who had a dislocated hip joint could not distinguish between hot water and a lump of ice. I shall mention in connection with this case that the sense of pain was also completely lost for almost one year, during which time he had frequent sores on his feet, the result of his shoes rubbing.

Motor paralysis comes on gradually, followed shortly afterward by atrophy. Muscular soreness and loss of tendon reflexes are frequent symptoms of multiple neuritis. The trophic changes in the skin are quite constant. Electrical changes are present to both the galvanic and faradic currents, and present the phenomena of the *reaction of degeneration*. Œdema is a later symptom and does not occur in all cases.

Pathology.—I shall not go into details of the pathology. I have not had any personal observation on this part of the subject, hence I could but repeat that which is to be found in all the recent text-books on nervous diseases and which is familiar to you all. Suffice it to say that following the conditions of inflammation involving the structures of the nerve fibres and their connective tissue, there is a fatty degeneration and absorption of the segmented layer of myeline or medullary layer and axis cylinder, or in other words, the process of degeneration

following the division of a nerve trunk. If the patient does well, after a few weeks or months, the process of regeneration sets in and the nerve regains, at least partially, its normal condition. The above applies in substance to that of multiple, as well as simple, neuritis, although in the former the process of regeneration is much longer delayed and more often does not regain the normal condition.

Diagnosis.—In the first place, then, we have to distinguish between neuritis and the various forms of neuralgia, such as sciatica, brachial and facial neuralgia, etc., and I believe that a great many of the so-called cases of sciatica are nothing less than neuritis of that nerve. The absence of fever and burning sensations, the periodicity and lancinating character of the pain, together with the *tic douloureux* of neuralgia, will be the principal points of distinction.

Dropsical effusion.—A careful examination of the urine, heart, lungs and liver, and the rapidly receding character of the *œdema* when in the recumbent position, diminished muscular response to the different electric currents, and the color of the skin will exclude these affections when encountered in the later stages.

Acute articular rheumatism.—In rheumatism the onset is more sudden, temperature and pulse higher, pain and swelling confined to the joints, pain increased by movements, and the characteristic sweats will aid in distinguishing it from this disease.

Poliomyelitis.—The greatest difficulty will be encountered in diagnosing between this affection and multiple neuritis. Until recent years this error has been made by the ablest diagnosticians; but in poliomyelitis the onset is more violent; often there is no prodromata whatever in poliomyelitis, the paralysis being complete from the beginning, which is never the case in neuritis, and the entire central nervous system shows the influence of the disease oftener than it does in neuritis; the paralysis is more symmetrical in neuritis than in poliomyelitis.

In poliomyelitis there is no pain along the nerve tract as in neuritis, and these nerve tracts are not sensitive. In poliomyelitis the lesion is central and affecting the motor areas of the cord; and while the motor paralysis is usually complete from its first appearance, the

sensory functions are very little, if at all, disturbed. This motor paralysis of poliomyelitis often involves groups of muscles of both upper and lower extremities at first, but in a few days there is a retrogression of the paralysis to a great extent; such retrogression does not occur in multiple neuritis.

The atrophy is much more rapid after poliomyelitis than multiple neuritis. The severe pains of neuritis are very rare in poliomyelitis, and when pain is present in the latter it does not persist for any length of time as in the former. The electrical reactions and reflexes may be as thoroughly affected in one disease as in the other. The differential diagnosis in many cases can be made only after close observation of the entire course of the disease.

Locomotor ataxia is a chronic disease, characterized by sudden atrocious, stabbing or lightning-like pains, which come in temporary paroxysms and are seldom continuous, and there is ataxia, the muscular strength is unimpaired, glossiness of skin and tenderness of muscles are absent; atrophy of the optic nerve is often present.

Treatment.—The first essential in the successful treatment of either form of neuritis is to put the affected nerve or nerves at absolute rest. In neuritis of the upper extremities rest is much more easily procured by placing the arm in a sling than by any other method. In sciatic neuritis the patient should be placed in bed; in fact many cases improve rapidly with proper rest, whilst otherwise they are most intractable. Dr. Weir Mitchell recommends the application of a splint from the arm-pit to the foot, and, as the disease is brought under control, have the patient abstain from walking as much as possible for some time.

In the beginning of both forms of neuritis the pain is the most distressing symptom and can only be controlled by opium or some of its alkaloids, with quinine, salicylate of soda and phenacetine. Dr. Landon Carter Gray, of New York, in a recent article on this subject, says: "There is not the slightest use in wasting any time in this initial pain of neuritis upon such analgesics as phenacetine, antipyrine or exalgine, or their congeners. Opium, and opium alone—and I say it boldly—can control this initial pain. We must therefore consider the

question as to whether our patient is of such a nature that he is likely to form the opium habit, and, if he is, we must look frankly in the face of the question as to whether it is best for him to suffer the pain or run the risk of forming the habit. It has been my experience that the patient is in no danger of forming such habit. In the many cases I have treated I have not yet made an opium-eater. Indeed, I think there is some subtle law at work here which prevents the person who is in *real* need of opium from becoming a slave to it."

In my experience I have not found cause to differ with the above assertions, further than to say that it appears to me that much less opium is required if combined with 2 to 4 gr. doses of phenacetine every fourth hour, provided the condition of the heart will permit its use. The opium may be given as morphia sulph. in doses of $\frac{1}{8}$ to $\frac{3}{4}$ gr. by mouth or hypodermically, and as often as the case may require. I give quinine and salicylate of soda, 2 to 4 grs. of each, every four hours in all cases, except in cases of multiple neuritis due to some infectious disease, when they do not appear to be of much service farther than the tonic effect of quinine, which should only be given in 2-gr. doses three times daily.

Hot applications to the limbs, such as hot hops and hot cloths, and hot salt-water baths will relieve the burning sensation and muscular soreness of multiple neuritis. After the pain becomes a minor factor electricity may be used, but in no case should its use be resorted to until the acute pains have ceased, or it will increase the pain to an unbearable degree. A beginning should be made with a very weak galvanic current, and after two or three weeks the faradic battery may be used, being extremely careful to use a weak current at first. The electrodes should be large and no attempt made to select any particular nerve for its application. The concentration of the electric current to a particular nerve will irritate it, and instead of doing good will be disadvantageous. The sittings at first should not be longer than two or three minutes, gradually prolonging them as the process of regeneration progresses. Gentle massage will be of service in the later stages, but care should be taken to not grip the muscles. The general health should be carefully looked after, and if anæmia be

present, iron in some of its forms and in full doses should be used, and in extreme cases of anæmia the malt extracts will be very beneficial. If there is not much anæmia and the patient's strength is well preserved, the bitter tonics with iodide of potassium will be of service. In multiple neuritis, and especially after the infectious diseases, strychnine in full doses will greatly add to the benefit of other remedies.

Arsenic, of so much service in all forms of neuralgia, is of little, if any, use in neuritis; on the other hand it may be a disadvantage, as it is capable of causing an acute neuritis, a fact which has been demonstrated by its heroic use in the treatment of chorea, and, if used at all, its effects should be carefully guarded.

Winifrede, W. Va.

SOME INTERESTING CASES OF DISEASES OF THE STOMACH.

BY DR. JULIUS FRIEDENWALD, '90.

REPORT No. 2.

The second case occurred in my service at Bayview Asylum. This case is of great interest. It presented a condition of dilatation of the stomach with contraction of the pyloric end, due to cicatrization of an old ulcer, which had run its course almost to termination without any symptoms. It is also of importance from the fact that at one time carcinoma of the stomach was diagnosed, owing to the seeming presence of nodules at the pyloric end, which on palpation simulated a cancerous growth, but which simulation later, on autopsy, was found to be due to well-marked depression on the left lobe of the liver, corresponding to the ribs and due to pressure by them.

Mrs. L., widow, multipara, aged sixty-three years, native of Ireland, was admitted to the medical ward September 14, 1895. On entrance she complained of paroxysmal pains in the chest, hacking cough, especially at night, dyspnea, anorexia, night sweats, evening elevation of temperature with morning remissions, attacks of diarrhea, and

hemoptysis. She was emaciated and very anemic. The blood count at various times showed the red blood corpuscles ranging in number from 1,800,000 to 2,000,000 to the cubic millimeter. The leucocytes were about normal in number. Phthisis pulmonalis was suspected, but a thorough physical examination at intervals revealed only a somewhat contracted hyper-resonant chest, prolonged, harsh expiratory murmur and occasionally a few bubbling râles on the left side. The right lung and heart were normal. Numerous examinations of the sputum failed to show the bacilli of tuberculosis. The urine was normal. At this time there were no marked indications of stomach trouble, and though the patient was seen by various members of the visiting staff, no diagnosis was made excepting emphysema and senility. Her symptoms did not ameliorate under treatment, and emaciation, cough, dyspnea and anorexia increased. Purgatives were always necessary for an action of the bowels. Blood was never noticed in the stools. She remained in this condition until about two months previous to her death. At that time she began to complain of pain in the epigastric region, dull in character, ill-defined and continuous but which was not usually exaggerated on taking food. The epigastric region was occasionally tense; always tender on pressure. The tongue was furred, the stools were irregular, with eructations of gas, and frequent severe headache. At times there were attacks of vomiting. The ejected matter, coffee-ground in character, was never large in amount, and the vomiting was not occasioned by food irritation. The ejected matter was never characteristic of gastrectasis, but was significant of carcinoma. Physical examination revealed a thin, relaxed abdominal wall, with some bulging in the right hypochondriac region. Occasionally a peristaltic wave could be detected, especially on mechanical irritation. Percussion, after one liter of water was administered, showed the lower border of the stomach to be seven centimeters below the umbilicus. Owing to the marked asthenic condition of the patient, no attempt was made to distend the stomach artificially, and it may be stated here that this fact accounts for our not making an examination of the stomach contents. The patient's condition contraindicated any attempt to pass a stomach tube. On palpation, we found what we

thought to be a mass of cancerous nodules at the pyloric end of the stomach, movable and slightly tender to the touch. The thin abdominal walls permitted palpation freely, and there seemed to be no ground for an error in the diagnosis. On auscultation, consecutive shocks by the hand produced the characteristic splashing sound heard in gastrectasis. The typical yellow hue of cancer cachexia was well marked. The diagnosis of carcinoma of the pyloric end of the stomach complicated with gastrectasis was made. The patient gradually failed, and two weeks prior to her death would only eat when forced to do so by her nurse. Death occurred November 10, 1897. Post-mortem, November 11. All organs very anemic. Stomach: Length of lesser curvature, 21 cm.; capacity, 1,800 cc. The mucous membrane was congested. The walls of the stomach were not thickened, being unattended by hypertrophy. The lesion—an ulcer—was situated on the posterior wall of the pyloric portion near the lesser curvature; it was of oval shape, five centimeters in diameter, and penetrated into the muscular layer. Its edges were thick and indurated, and the floor was smooth and pigmented. The pylorus had participated in the contraction following cicatrization, and its opening measured but six millimeters. Liver: Weight, 1,170 grams. The left lobe presented several depressions on its surface corresponding to the ribs. Left lung: Lower lobe emphysematous. Other organs normal.

The third case represents that rare condition of the stomach in which a carcinoma has developed upon the base of an old ulcer, the co-called *Ulcus Carcinomatosum*. In consequence of the pyloric ulcer there was a marked dilatation of the stomach.

The patient, M. S., a female, age 51, entered the City Hospital November 2, 1896. Her family history was good. For the past eight years her health had been bad; her abdomen would swell and she had severe pains in the abdomen after eating, and frequent vomiting spells. On examination of the abdomen no resistance could be made out; the right kidney was found slightly movable, the stomach dilated, reaching three fingers' breadth below the umbilicus. The gastric contents, removed an hour after an Ewald test-breakfast, showed an acidity of .2 per cent. free hydrochloric acid; it formed the well-

known three layered contents so characteristic of dilatation of the stomach; sarcinae were found in abundance. The patient continued to suffer a great deal of pain in the stomach and vomited often material eaten the day before. Lavage was practiced daily, but notwithstanding this the patient emaciated rapidly and the vomiting still continued. Leube test-dinners were frequently given and removed at the expiration of twelve hours. In all instances food remains were obtained of a high total acidity (80-100) and .2 to .3 per cent. of free HCl. The patient steadily lost flesh and became weak, and it was determined to open her abdomen and perform a gastro-enterostomy.

On January 27, 1897, Professor J. W. Chambers opened the abdomen and found a contracted pylorus, a dilated stomach, enlarged mesenteric glands and a small nodule in the right lobe of the liver. Gastro-enterostomy was performed. The patient never rallied from the operation and died four days thereafter. After death the stomach and part of the liver were removed. The stomach held 1,820 cc. of water. The interior of the stomach was much congested and the walls of the stomach thickened. On the interior was a sharply defined cicatrized ulcer within the pylorus and adjoining its posterior and greater curvature. The greatest diameter of the ulcer was five cm., corresponding to the lesser curvature of the stomach; its lesser diameter, $1\frac{1}{4}$ cm. The base was rough and filled with polypoid masses. The circumference of the ulcer was deeply infiltrated by a hard mass reaching 55 cm. above the base and dipping down through the peritoneal coat into the left lobe of the liver. The liver weighed 1,470 grammes, and was congested throughout. The left lobe contained a cancerous nodule 1 cm. in diameter, which was firmly adherent to the posterior portion of the stomach in the region of the pylorus. Microscopically, the edge of the ulcer and the nodule in the liver showed a similar condition. The carcinoma was the cylindrical cell variety.

OVARIAN CYSTOMA WITH FIBROMA AND SARCOMA
OF OVARIES AND TUBE.

BY DR. A. SAMUELS, '98.

FROM THE CLINIC OF DR. THOMAS OPIE.

Mrs. J. E., age 69, colored. Family history negative. Previous history good. According to the patient's statement her abdomen began to enlarge about eight months ago, with the usual pressure symptoms.

Her abdomen was greatly distended and breathing somewhat interfered with. On percussion the dullness was limited to the central portion of the abdomen, the flanks being resonant. The dullness did not change when position was altered. On palpation the abdomen fluctuated, and she had some pain in the right ovarian region.

The above examination having been made, operation was determined upon. The chief factor against operation was her age. Her general condition was very good.

The patient was prepared in the usual aseptic way for a *cœliotomy*. The incision was made in the median line high up, about three inches above the symphysis pubes, so as to avoid the possible danger of cutting the bladder. Nevertheless, in opening the peritoneum a small incision was made into the bladder, an unavoidable accident in this case, as the bladder had become firmly attached by adhesions to the peritoneum and was greatly displaced by the growing tumor. The adhesions were not the kind usually encountered, but were broad, thick and inseparable. The omentum was fibrous in character and firmly adherent to the bladder and tumor. After much difficulty the tumor was reached and aspirated. The fluid was of a chocolate color and rather thick. The tumor was so firmly attached by adhesions that it could not be removed except at the expense of the intestines. In the left ovarian region there was a large mass, quite hard and immovable, surrounded by adhesions, which, however, were not so dense as those previously encountered. This mass was carefully separated and removed by placing a ligature around the pedicle and

cutting close to the ligature. In separating and breaking the adhesions some points bled profusely and the actual cautery was applied. In the right ovarian region there was another mass, softer and smaller in size than the mass on the opposite side, which was also removed.

The abdominal cavity was flushed with normal salt solution and all bleeding points cauterized.

The sac being irremovable, the mouth was sutured to the abdominal wall and a glass drainage tube inserted. The abdominal wound was closed in the usual way and protected. The patient recovered promptly from the ether and very little shock followed. Four hours after the operation she passed her urine.

The next day the sac cavity was cleansed. This was done every day. The patient did nicely up to the 11th day after the operation, when she began to show signs of exhaustion. The usual remedies were given, but to no avail. Death occurred on the 14th day.

Pathology of the fluid and growths.—The fluid was of a chocolate color and odorless; sp. gr. 1025; reaction neutral. Chemically it contained paralbumen. The microscope revealed red and white blood corpuscles, crystals of cholesterine, uric acid, and some cylindrical epithelium. The growth in the left ovarian region measured 4.5 cm. in its long diameter and 2.5 cm. transversely, was irregular in shape and subdivided into three lobes. The whole was inclosed in a tough capsule which stripped off easily. Macroscopically on section the growth showed the characteristic appearance of a fibroma; in one of the lobes calcification had taken place. Microscopically the usual histological elements of these growths were present. The growth in the right ovarian region measured 1.35 cm. in its long and 1.5 cm. in its tranverse diameter. It was irregular in shape and not inclosed in a capsule, and had a rough and granular surface. Macroscopically on section the growth appeared as a homogeneous mass. Microscopically the characteristic elements of round cell sarcoma were found.

Conservative Gynecology and Electro-Therapeutics, a Practical Treatise on the Diseases of Women and their Treatment by Electricity. Third edition, revised, rewritten and greatly enlarged. By G. Betton Massey, M. D. Illustrated with twelve full-page original chromo-lithographic plates in twelve colors, numerous full-page original half-tone plates of photographs taken from nature, and many other engravings in the text. Royal octavo. 400 pages. Extra cloth, beveled edges, \$3.50 net. The F. A. Davis Co., publishers, 1914-16 Cherry St., Philadelphia; 117 W. Forty-second St., New York City; 9 Lakeside Building, 218-220 S. Clark St., Chicago, Ill.

Dr. Massey has given us a very complete book upon the therapeutics of electricity in gynecological cases. The author does not claim that all the diseases that women are heir to can be cured by currents of electricity, but he insists that within certain well-defined limits there is a large field for the use of electricity as a therapeutic agent. He then proceeds in a systematic way to point out such conditions as in his own experience can best be treated by this method, and details the manner of application. The fact that the book gives Dr. Massey's personal results and the doctor's well-known integrity make the book a valuable contribution to medical literature.

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THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

THE PATENT ON DIPHTHERIA ANTITOXIN.

After five distinct rejections the Board of Appeals finally granted a patent to Prof. Emil Behring for diphtheria antitoxin on June 21st, 1898. As a result the manufacturers who represent him have given notice to all American manufacturers to stop at once the manufacture and sale of antitoxin under threat of legal prosecution. It is perfectly well known that Behring has not and never can obtain a patent for what he claims as his invention in Germany, and it is a painful surprise to American physicians to learn that the United States patent officials could be induced to grant a patent to one who is so clearly not entitled to it. It is not to be denied that Behring has done much valuable work in serum therapy, but the same can be said of hundreds of other just as competent and just as earnest workers; and the glaring injustice of granting a patent to one worker to the exclusion of all others is so flagrant that it will be and is resented by every American physician.

There is hardly a question that the patent will not be upheld by the courts, but before it is finally decided the manufacturers and selling agents will in all probability, by threats of prosecution, attempt to intimidate the sellers and users of American-made serums. It would be only meting out justice to these would-be monopolists if every American physician would make a point of avoiding the use of

any serum with the brand "Made in Germany," and use only serums of American manufacture. There is no question that the American serums are perfectly efficient and reliable. Personally we have used Parke, Davis & Co.'s serum and propose to continue to do so. Parke, Davis & Co. have made complete arrangements to protect and defend from any legal proceedings any one who may be prosecuted for the purchase, sale or use of their serum, they assuming the entire expense of the defense.

In this issue we publish a number of letters from alumni, which we are sure will be eagerly read by their fellow-classmates. Let us have more of them. It is the spirit in these letters that is the life of the JOURNAL, and the more writers of letters we have the more news we can give in return.

The following alumni attended the recent meeting of the Virginia State Medical Society at Virginia Beach; S. T. A. Kent, '82, Ingram, Va.; B. D. Dutton, '72, Lott, Va.; J. H. Abbitt, '92, W. Appomattox; J. H. Mapp, '89, Buena Vista; R. M. Slaughter, '79, Theological Seminary; L. F. High, '91, Danville; W. B. West, '85, Fort Worth, Texas; A. S. Priddy, '89, Keysville, Va.; B. C. Keister, '82, South Boston; T. E. Peery, '95, Bluefield, W. Va.; C. W. Pritchett, '86, Danville, Va.; J. W. Preston, '93, Keystone, W. Va.; J. C. Baum, '94, Land of Promise, Va.; C. W. Jones, '94, Red House, Va.; J. Milton Lewis, '92, Roanoke, Va.; R. S. Martin, '84, Stuart, Va.

The meeting was a great success both in numbers in attendance and in the character of the papers read. Every one, and especially the writer, had a first-class time, and we all want to go again.

We will be very glad if some of the Alumni can furnish us with the address or any information concerning any of the following gentlemen. We wish to keep our list as complete as possible: N. N. Alderson, '94; O. D. Aultz, '91; John A. Bachman, '87; Wm. H. Bogwell, '83; L. L. Banner, '83; B. W. Burt, '86; Jas. O. Byrd, '74; J. M. Cain, '79; A. W. Chisholm, '94; B. F. Church, '88; W. E.

Clymer, '90; J. H. Colson, '96; Alfred Christie, '97; J. M. Crook, '85; A. T. Crussett, '97; L. F. Elstein, '95; K. Enlind, '93; Francis Erwin, '88; G. D. Fink, '95; J. E. Free, '82; E. J. Galligan, '96; G. F. Galloway, '94; F. H. Gardner, '91; W. R. Graham, '84; W. A. Hahn, '82; H. C. Haning, '94; F. W. Harper, '96; J. A. Hartshon, '94; Arthur Hawkins, '95; G. H. Hess, '97; J. C. Holdsworth, '96; J. M. Horton, '90; Ed. Jeffers, '97; J. Kascynski, '97; W. S. Kuhlman, '80; T. S. Lippincott, '88; H. McD. Little, '80; J. H. A. Lofland, '76; J. T. Loughridge, '84; T. B. Lovelace, '83; J. H. Martin, '93; V. W. McCoy, '87; J. C. Meredith, '85; L. B. Miller, '91; C. P. Monro, '92; S. M. Moore, '88; D. V. Moyer, '82; L. S. Nicholson, '90; L. J. Nite, '92; R. V. Palmer, '94; A. L. Patterson, '73; T. H. Perry, '95; W. V. Philbruk, '85; B. C. Pilkey, '96; G. W. Rash, '94; F. A. Rhoads, '82; J. N. Roe, '89; Ben. Russell, '96; C. H. Saunders, '91; L. R. Shaffner, Edwin Small, '81; A. W. Smith, '95; R. O. Smith, '85; R. O. Smith, '86; R. E. Sparks, '77; E. J. Spratling, '91; Wm. H. Stevens, '89; G. C. Stewart, '78; Jno. P. St. Clair, Charles Toole, '86; D. C. Turner, '80; P. G. Vorgtlen, '96; M. B. Webb, '84; W. V. Welst, '83; W. H. Whittle, '82; S. J. Windsor, '86; Amos D. Wood, '93; S. M. Yancey, '86; Guy E. Barker, '87.

Personal Notes.

DR. W. WAYNE BABCOCK, '93, is resident physician at the Kensington Hospital for Women, Philadelphia.

DR. J. M. WHITE, '97, is practicing in St. Louis, Mo. His special line of work is rectal and genito-urinary surgery.

DR. ALEXUS MCGLANNAN will lecture this year at the College on inorganic chemistry and physiological chemistry.

DR. WILLIAM S. GARDNER, '85, will deliver the didactic course on gynecology during the next regular college term.

DR. C. J. CAREY, '97, has been appointed assistant physician to the Second Hospital for the Insane at Sykesville, Md.

DR. H. C. KNAPP, '96, who has been physician to the Insane Department at Bayview, left for New York, July 1st.

DR. T. E. PEERY, '95, is located at Bluefield, W. Va. He is devoting himself to diseases of the eye, ear, nose and throat.

DR. I. C. HALLINGER, '82, has opened a sanitarium in New Albany, Ind. He was in Baltimore for two weeks during August.

DR. M. J. BARTLETT, '95, of Clarksburg, W. Va., paid Baltimore a short visit recently. He is enjoying a large and lucrative practice.

DR. SEATON NORMAN, '81, resigned from the Marine Hospital service and was immediately appointed chief surgeon of volunteers, with the rank of major.

DR. W. B. WEST, '85, of Fort Worth, Texas, says that the Lone Star State is the only State to be contented in. Any one once there becomes fascinated and remains to the last day.

DR. G. E. ROBISON, '97, and DR. CHAS. JENSEN, '97, stood first and second respectively in the Utah State Board examination. The pace they set was too fast for the other applicants.

DR. JOHN C. MORFET, '95, who was resident gynecologist at the City Hospital the year after his graduation, has a good practice in St. Louis, Mo. He is devoting himself to gynecology and general surgery.

DR. D. A. BERNDT, '96, is now studying general medicine and surgery in the "Allgemeinen Krankenhaus" in Vienna. He intends taking a two years' course in the larger hospitals and clinics of Vienna, Berlin, Rome and London. There are very few Americans in Europe this year—there being about twenty-five in Vienna this summer—but the College of Physicians and Surgeons was well represented, as it had four men there—A. G. Aldrich, '79; N. T. Carswell, '86; Pearl Williams, '96, and D. A. Berndt, '96.

DR. GEO. W. BOYD, of the class of '95, is rapidly becoming one of the most prominent practitioners of Washington, D. C., where he located after his graduation. There in two years his skill and popularity have enabled him to build up a really phenomenal practice. The Doctor is the possessor of a magnificent office and residence, besides a very imposing four-story brown-stone and Milwaukee brick dwelling-house, just completed at a cost of almost twelve thousand dollars.

DR. A. G. ALDRICH, '79, is now in Vienna attending special courses and clinics on eye and ear diseases. Until the Doctor left for Europe he has been very successfully practicing medicine at Anoka, Minnesota. Since coming to Europe the Doctor has had a "good thing" of it. He was late Clinical Assistant of the Royal London Ophthalmic Hospital and Central London Throat and Ear Hospital, London, England. He will return to America, and after April 1, 1899, will locate at Minneapolis, Minn., where his practice will be limited to eye and ear diseases.

LONG EDDY, N. Y., July 11th, 1898.

DR. WM. J. TODD.

Dear Doctor.—The copy of JOURNAL of the Alumni Association reached me, being remailed from Fish's Eddy. I very much enjoyed looking over its contents. My most ardent thoughts center, the faculty excepted, on the men of '92 and a few acquaintances of '91, to whom I hope, through the JOURNAL, to communicate the following evidence of my continued existence. The Legislature of New York State decided in '91 that a 3 years' course was necessary in preparing for the practice of medicine, so I took the course of '93 at the University of Buffalo, N. Y., and received their diploma in May, '93, and a month later passed the examination of the New York State Board, and have since laid a tribute of \$2500 a year for my services for about 1200 people inhabiting a circuit of an eight-mile radius. I am a member of the New York State Medical Association and examiner for the New York Equitable, the North Western of Milwaukee, the

Phoenix Mutual, and the New York Provident Savings Life Associations. I intend to be present at the meeting of the Alumni Association next year, though with no physician nearer than eight miles it is hard to get away. I offer the suggestion that all who intend to be present at the next annual meeting inform the editor of the JOURNAL, and that the names be published in the two numbers preceding the meeting. This would be a stimulus to many to be present, on the expectation of meeting classmates from a distant part of the country.

Yours truly,

B. W. STEARNS.

PATERSON, N. J., July 11th, 1898.

William J. Todd, M. D.—I am pleased that at last we have a means at hand to learn the whereabouts of our old college chums. I gladly enclose check for subscription and hope you will make a success of the JOURNAL. I would like to hear from my class of 1887 "graduates." I am located in this city (Paterson, N. J.) since 1888. I practiced in Southbridge, Mass., from 1887 to 1888, then located here. I was elected City Physician in 1889, which position I have held ever since, and have just been re-elected for three years more, at an increased salary. I am also a member of the Board of Health in this city. I am chairman of hospital committee in charge of Isolation Hospital for Contagious Diseases, one of the finest institutions in the country. I am also Physician in Charge of the County Insane Asylum and City Almshouse, and until recently on the out-door department of Paterson General Hospital. Independent of this I have a very nice practice. Our city contains one hundred and ten thousand people, and you can imagine I am busy most of my time. I forgot to say that as City Physician I am also Surgeon in Charge of Police Department, also Fire Department. Do not think I am sending you this for publication; I merely feel proud for the sake of my old College, and I want her to be second to none in this country.

I often see Dr. Evans at Morris Plains State Hospital for the

Insane. He is a graduate of P. & S. Dr. Emerson, also a graduate of P. & S., is located here and doing well; was a student of mine. Dr. Cook of '87 I understand is in Dover, N. J., doing well, although I have not had a chance to see him; I mean to do so before long. Can you not induce them all to "give an account of themselves"?

I will not take up more of your time. Success to your venture; let every man from P. & S. help it along, it is a good thing.

Respectfully,

THOS. L. PATON, M. D., 1887.

AITAT, MT. LEBANON, SYRIA, May 22nd, 1898.

My dear Doctor.—I begin this letter by praying you and all those who will read the present to excuse the English of a foreigner speaking a language which is not his own.

I received the JOURNAL of the Alumni Association with an indescribable joy. Its aim and spirit are worthy of the pride of every graduate of the College of Physicians and Surgeons, and gives us an encouragement in our work and a great satisfaction and happiness; this is specially true of us who are separated from their honorable teachers and beloved friends by so many thousands of miles. We are here as a colony which always think about their mother land, *i. e.* the college from which they guard a very good souvenir. Everything that relates to our college and to our classmates gives us the greatest interest.*

I read the JOURNAL and was deeply interested all through. I intend to translate some of its contents into an Arabic medical paper in my country to which I contribute from time to time, so that our college will be better known here.

I can't pass under silence one thing that I read in the JOURNAL and which caused me the greatest sorrow. I mean the death of able, beloved and honorable Professor Dr. G. Thomas. Truly it is a great loss for our college and a cause of keen sorrow for any one who has known him. May God give patience to his respectful family to stand courageous by that great loss.

Please kindly tell me if all the members of the Association can correspond with the JOURNAL (*i. e.* contribute to it) or this privilege is limited to those who are active members only?

I close my letter praying you to write my name in the list of the *abonnés* of the JOURNAL (for which I enclose a dollar) and to present my respect to all the members of the honorable faculty of our college and my best wishes and remembrance to all my classmates of '97.

Yours very truly,

SALEM TALHOUK, M. D.

JACOBUS, PA., August 5, 1898.

Dear Doctor Todd.—The Alumni JOURNAL comes to me like a visit of an old friend—always bringing good news of the rest of the family. Have been conducting a successful practice at this place for the past eleven years; have lately been honored by being appointed a member of the Board of Congressional Referees for the 19th congressional district of Pennsylvania.

With best wishes for all the boys, I am yours for success,

F. J. SNYDER,

Class of '86-7.

MADONNA, MD., August 11th, 1898.

My dear Dr. Gardner.—It gives me great pleasure to acknowledge receipt of a copy of the JOURNAL of the Alumni Association of the College of P. & S., Balto., July, 1898. I also desire to say that it shall have my most earnest support, and will assure you that it will always be my pleasure to meet the Association in fraternal greetings; also to enhance the high honor, standing and prosperity of our much beloved alma mater.

With many kind wishes, I am fraternally yours,

W. C. McCURDY, '74.

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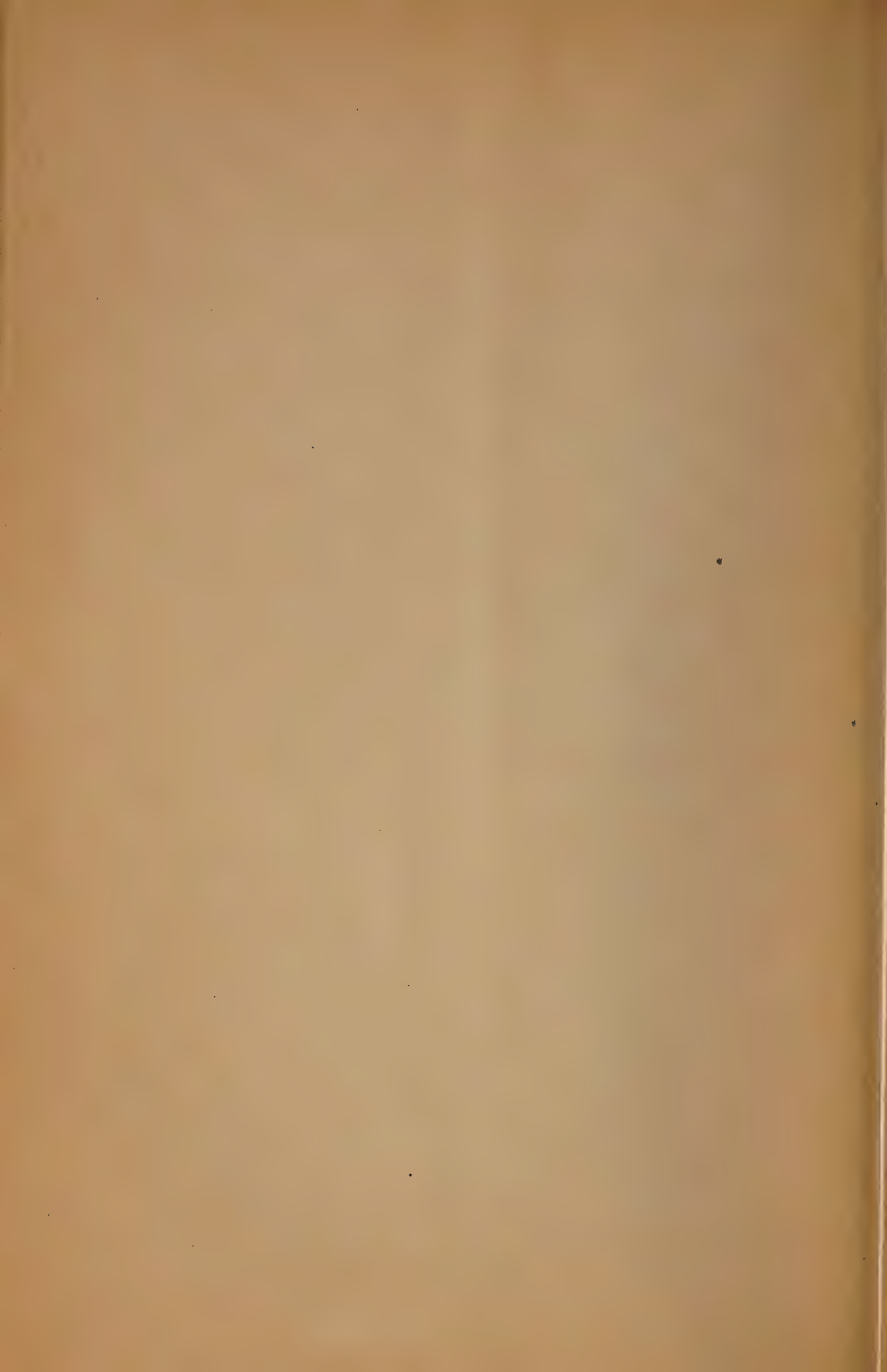
THE JOURNAL
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OF THE
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Vol. I

No. 4

JANUARY, 1899

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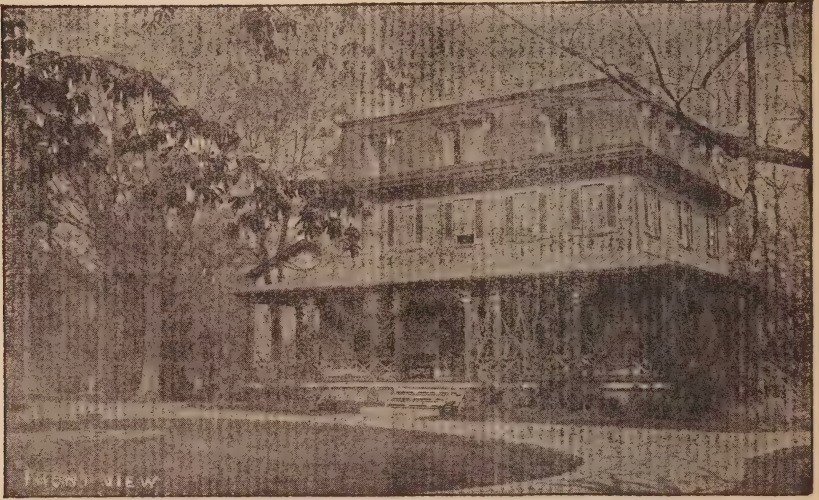
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REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
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Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Personal Notes.

DR. A. T. CRASSET, '97, is practicing at East New Market, Md.

DR. A. M. HOLMES, '85, is succeeding well in his practice in Denver, Col.

DR. THOS. S. LOWE, '97, is in the army and at present is stationed at Jefferson Barracks, St. Louis, Mo.

DR. FRANK J. COLLISON, '88, is located in Columbus, Ohio, where he owns a drug store and is practicing.

DR. SHELDON G. EVANS, '90, now ranks as past assistant surgeon in the Navy, and is now on the Marblehead.

(Table of Contents on Page V.)

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Personal Notes.

DR. L. F. ANKRIM, '86, of Pittsburgh, was in Baltimore for a short time recently. He was here long enough to subscribe for the JOURNAL.

DR. JOHN C. MORFIT, '95, was elected second vice-president of the Miss. Valley Medical Association at the annual meeting held in Nashville in September.

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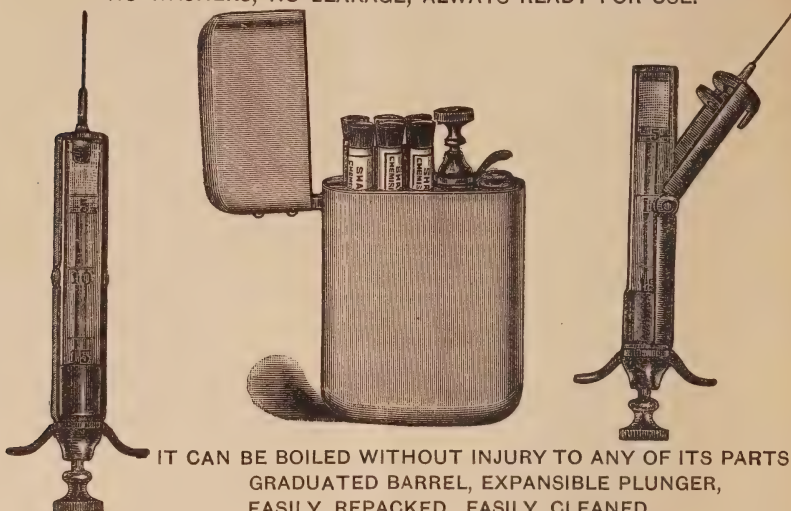
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THE JOURNAL
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COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

PUERPERAL ECLAMPSIA. REPORT OF CASES SEEN IN
THE SERVICE OF DR. L. E. NEALE AND DR. C.
HAMPSON JONES AT THE MARYLAND
LYING-IN ASYLUM AND IN
PRIVATE PRACTICE.

BY DR. CHAS. E. BRACK, '95.

The consensus of opinion at the present time is that the phenomena occurring in an attack of eclampsia are the result of a toxæmia.

Post-mortem examinations have shown that most frequently an acute congestion of the kidneys (Schwangerschaftsnieren) existed; less frequently acute or chronic parenchymatous nephritis. Sometimes the liver was found diseased. Collins found involvement of the cerebral arteries even in young women. Marx has classified eclampsia as resulting: First, from toxæmia due to heart disease; second, from acute toxæmia due to an exacerbation of chronic nephritis; third, acute toxæmia due to acute nephritis; and fourth, true urinaemia. He claims that the quantity of urea in the daily amount of urine is a better guide than the quantity of albumin.

There are probably two fundamental conditions: One a hyperexcitability of the nervous system, and the other a toxæmia. One or the other predominates, though both are co-existent.

The urine is usually scant and shows albumen with hyaline and granular casts.

At times no albumin is found before the attack, but is found after convulsions have occurred.

Eclampsia comes on most frequently during labor, next in frequency before labor and least frequent after delivery.

The prognosis is less grave at term and less grave during labor.

Premonitory symptoms are increasing albuminuria, decreased amount of urine, flashes of light, increased irritability of the vascular system, rapid and wiry pulse, increasing anæmia, disturbance of vision, persistent or recurring headache and digestive disturbances.

The prognosis should always be guarded. Some cases apparently not severe do badly; others which seem almost hopeless recover.

Most cases can be beneficially influenced by prophylactic treatment, consisting of absolute milk diet, free purgation by salines, diaphoresis by hot baths, cardiac stimulants and diuretics if indicated. Thus using every possible means of stimulating emunctory functions and ridding the system of toxic agents.

Convulsions usually cease when the fœtus is delivered or when it dies in utero. On the other hand, any forcible interference increasing reflex excitability naturally increases the liability to convulsions. The treatment depends entirely upon the nature of the case and the judgment of the physician.

From a conservative standpoint the experience of most obstetricians will permit us to crystallize proceedings upon the following:

If convulsions occur before labor, and if labor is not induced by the eclampsia control convulsions (chloroform, morphine, chloral, veratrum viride, venesection), increase elimination of toxins (croton oil, salts, hot air or steam bath). If patient responds to treatment and improves let well enough alone and continue treatment. If, on the contrary, the condition is not favorably influenced, induce labor and deliver as rapidly as is consistent with the safety of the patient (dilatation, incision, version, forceps). When eclampsia occurs during labor treat patient as above and wait; if labor is slow in second stage, apply forceps; if slow in first stage, and patient not responding to treatment, dilate with Barnes bags Colpeny uter and apply forceps.

J. N. C., aged 17, colored, primipara; brought to the Maternite in labor. Convulsions during first stage. Digital dilatation and by Barnes bag. Chloroform, chloral, salines. Forceful dilatation of os by head using Taylor's narrow blade forceps. Delivery by Tarnier's axis traction forceps. Several convulsions followed delivery. The patient remained comatose until death occurred on following day. Child born dead. Urine contained albumin and casts. Pulse ranged from 120 to 130. Temperature from 103.5 to 104.5.

Patient very stout, limbs œdematous, kidneys congested, liver fatty, spleen enlarged.

K. M., aged 24, brought to the Maternite in labor, primipara; limbs œdematous. Convulsions during second stage; became conscious after third convulsion. Chloroform, steam bath, croton oil, salines by enema, morphine $\frac{1}{4}$ grain every 4 hours. Delivered without instruments; child living. Had three convulsions after delivery, the last at the expiration of twelve hours; recovered. Pulse 118, temperature 99—maximum.

Urine showed hyaline and granular casts, blood cells and large quantity of albumin. Subsequent treatment—salines, Basham's mixture and milk diet.

E. S., aged 30, white, primipara; admitted five weeks before confinement. History of rheumatism. Chronic endocarditis, excessive œdema of limbs, face puffy, urine contained large quantity of albumin and casts, quantity diminished; specific gravity varied from 1010 to 1040. Patient had nausea, headache, disturbance of vision. Limbs bandaged; administered salines, infusion of digitalis and tincture of iron. After delivery, which was rather rapid, child being very small, muscular twitchings came on, eyes became staring, face suffused. Rather profuse post-partum hemorrhage occurred, and was only arrested by packing uterus and vagina with gauze. No further manifestations, and recovery. Two years later patient again admitted about six weeks before labor; condition about the same as before. Same treatment adopted. Delivery uneventful.

R. B., 19, colored. Admitted four days before labor. Marked œdema of legs. Urine contained large amount of albumin and casts. Complained of nausea, persistent headache, disturbance of vision.

Given large and repeated doses of salts, hot baths, infusion of digitalis with potassium acetate. Improved and was delivered without trouble. Pulse 100, temperature 100 before labor.

M. T., 30, colored. Admitted in labor. Marked œdema of legs and abdominal wall. Urine contained albumin and casts. Patient stupid and roused with difficulty. Delivery rather rapid. Postpartum hemorrhage. No convulsions. Pulse before labor 110.

E. S., 15, colored. Admitted in labor. Œdema of legs, face puffy, headache, vision disturbed. Urine contained albumin and casts. Labor tedious, lasting 24 hours. Convulsions during second stage. Chloroform, saline enemata. Delivery by high forceps when os was nearly dilated. Anæsthesia discontinued. An hour after delivery another convulsion; controlled by chloroform; chloral and morphine in repeated doses; salines. Child dead. No further convulsions. Temperature never above 100. Pulse after delivery 102, dropped to 56 by third day, then gradually rose to normal. Recovery.

L. C., colored, 19. Œdema of limbs. Albumin and casts in urine. Treated for ten days before confinement; milk diet, salines, digitalis infusion with acetate of potassium. Convulsions came on 24 hours after delivery. Three convulsions fifteen minutes apart, three more at intervals of half hour, comatose after last convulsion. Chloroform, chloral, steam bath, salines. After treatment salines. Recovery. Pulse 158, temperature 102 during eclampsia.

Mrs. H., white, 19, primipara; about 9 months pregnant. Robust, but of a nervous, excitable temperament; a voracious eater and addicted to beer, not always in moderation. Patient had enjoyed good health until two days before attack, when headache, nausea, dizziness and dimness of vision occurred. Dose of salts given. On following day patient was better and ate very heartily. Urine examined and found to contain large amount of albumin. Limbs slightly œdematous.

On following day convulsions occurred, patient comatose. Chloroform and $\frac{1}{4}$ grain morphia, saline enemata. A third convulsion occurred two hours later, followed by coma lasting about three hours. Diaphoresis by means of hot baths, blankets, pilocarpin one dose, steam bath. Two drops of croton oil were placed on tongue; four hours

later bowels were moved; stools contained large quantities of undigested food. Pulse 150, temperature 102. After bowels had been freely moved patient became conscious, and labor pains came on, the os dilated rapidly and ten hours later a still-born child was delivered. Patient conscious.

Salines, infusion of digitalis with acetate of potassium and bromides were given. Strictly milk diet until all albumin had disappeared from urine at the end of two weeks. Within twelve hours after delivery patient became blind for nearly four days. Temperature $97\frac{1}{2}$, pulse 145, respiration 58 on day following delivery, reaching normal on fifth day. Entire recovery. Patient has since been delivered of a healthy child without any recurrence of symptoms.

Mrs. K., white, primipara, nervous temperament, hearty eater; suffered with attacks of indigestion from time to time during gestation. Urine free from albumin, specific gravity normal.

In labor at term for ten hours; head on perineum when, suddenly patient began to breathe heavily, rolled her eyes upward, turned head to one side, limbs became rigid, face suffused and clonic convulsions followed. No prodromal symptoms whatever. Chloroform given immediately and child delivered by forceps alive. Anæsthesia continued, and no further convulsions occurred. Hot steam bath given, saline enema, bromides and chloral by rectum in repeated doses. Chloroform discontinued after three hours. Patient semi-comatose for ten hours. Pulse 150, temperature 102. Half drop of croton oil every half hour—four doses. After that time patient became conscious. Salines, digitalis, milk, diet, later strychnia and iron. Urine contained small amount of albumin and hyaline casts after delivery. Pulse remained feeble and rapid for ten days, when it gradually returned to normal. Perfect recovery.

M. S., 17, colored, primipara. Seen at 10 A. M. Marked œdema of limbs, labia majora and lower abdominal wall. Œdema had come on within two days. Urine contained no albumin or casts. Salines given, and labia punctured with bistoury. At 1 P. M. convulsion occurred followed at intervals of half hour by two more. Headache, vomiting and abdominal pain preceded convulsions.

Os dilated to admit one finger. Chloroform, half drop croton oil.

in pill every half hour, saline enemata. Steam bath. Morphine in half-grain doses hypodermatically every four hours. At 7 P. M. labor had made but little progress; foetal heart sounds still heard; chloroform had been given whenever pulse began to increase in frequency, and was now discontinued. Patient semi-conscious. Pulse 84, temperature 100.2. Bowels moved.

On following morning patient was conscious; last hypoderm of morphine $\frac{1}{4}$ grain given. Pulse 100, temperature 100. Foetal heart sounds not heard. Salines by mouth. Os dilated to admit two fingers, labor progressing slowly.

First stage completed at 7.30 P. M. Membranes ruptured and dead foetus delivered at 9 P. M. by low forceps. Amniotic fluid scant in quantity. Pulse during attack 158, temperature 100. Recovery.

A. T., 19, primipara. Eight month child delivered 10.30 P. M. Delivery normal. Patient rested well all night. 7 A. M. following morning had slight convulsion. Chloroform enema, steam bath, croton oil. Convulsions continued every half hour until 12 M., then every hour or two until 5 P. M. Convulsions ceased. Heart began to fail in spite of cardiac stimulants administered liberally. Died at 11.55. Temperature 100 to 105, pulse 95 to 145. Urine loaded with albumin, specific gravity 1035.

THREE CASES OF OPEN AND INFECTED JOINTS.

By DR. G. S. McREYNOLDS, '98.

Case I. Service of Dr. C. F. Blake, City Hospital. J. O. D., white, aged 32 years, laborer, American; family and previous histories unimportant. On night of August 17, 1898, while crossing a trestle about 30 feet high, he fell to the ground, lighting on his hands, producing a deep cut in palm of left hand and producing a complete compound dislocation of right wrist, the ulna and radius with the semiluna protruding through a transverse tear of the skin on palm or surface of wrist. Circulation of hand remaining quite good. These protruding bones stuck into the ground and had a great deal of dirt grounded into the tissues.

On admission to hospital, 1 A. M. August 18th, patient was cleaned up as well as could be without giving general anæsthetic, wrist wrapped in wet bichloride dressing, and remained there until noon of August 18th.

At this time patient was placed under general anæsthesia, and parts cleaned up, and dislocation reduced, after removal of semiluna, drainage being placed in wound.

August 19th. Gauze drainage placed in wound does not seem to be adequate, there being considerable boggyness on dorsum of wrist. This point of boggyness was freely incised and a large quantity of pus drained off. Temperature 102° .

August 21st. There is still considerable formation of pus which does not drain as freely as it should. Have placed a rubber tube in joint passing from palmar to dorsal surface, and placed the wound under continuous drainage of a saturated solution of boric acid. Temperature still ranging from 100° to 102° . Heart irregular. Patient is being dressed every day with bichloride solution and drainage tube kept open.

August 26th. Temperature went to 104° to-day. He suffers a great deal and has to be kept constantly under influence of opiate.

September 1st. He has very little appetite, was given strychnia sulph., grain $\frac{1}{30}$, three times a day. Temperature 99° to 101° . Still large quantity of pus, but is drained very well.

September 2nd. About 3 P. M. was called to see patient in a great hurry with the statement that he was bleeding to death. On reaching him I found that he was bleeding quite freely from his ulnar artery, this being the only bleeding he has had since the injury was received. He had lost a good deal of blood before I could get to him and was in a collapsed condition. I succeeded in stopping hæmorrhage by means of direct pressure for about one hour. In the meantime he was given strychnia $\frac{1}{30}$ gr., whiskey $\bar{3}$ i, and a rectal injection of normal salt solution $\frac{1}{2}$ pint.

In course of 4 or 5 hours he rallied from the hæmorrhage very well, but he is very weak generally. The wound is still being dressed every day. Heart not so intermittent as it has been.

September 10th. Condition of patient and wound somewhat improved.

September 20th. Temperature runs about normal and patient feels better. He was allowed to sit up.

September 22nd. Discharge of pus has diminished very much. Drainage tube removed and continuous drainage discontinued. Wound is being dressed every other day. Patient feels much better. Has good appetite and is gaining strength rapidly.

October 1st. Wounds about wrist have about healed, but fingers are stiff. The wrist joint is not very firm and requires splint to support it.

October 12th. Wounds have healed, but wrist and fingers are still stiff, and there is loss of sensation over distribution of ulnar nerve. The elbow evidently received some contusion, as flexion and extension is not much more than half what it should be.

November 1st. The hand is exceedingly well nourished and there is some movement in the fingers and thumb.

December 1st. There is still some improvement in movement of fingers, but pronation and supination are entirely lost.

I think he will finally have a hand that will be very much more serviceable to him than a stump or artificial hand could possibly be.

The wound of left hand healed very nicely.

Case II. Service of Dr. C. F. Bevan, City Hospital. John L., white, aged 10 years, newsboy, American. September 7th, about noon, patient was pushed off a street car and was caught by car, dragging him for a short distance, receiving skin wounds of hip, thigh and leg on left side.

The left foot between internal malleolus and heel had the skin torn off for a space two inches wide by three inches long, but did not go deep enough to injure vessels and nerves in this location. On outer side of same foot the skin was entirely destroyed on dorsum for a space one inch wide and two inches long. In addition to this, over outer malleolus the tissues were destroyed down to the bone *opening the joint*; in front of the joint the dorsal bones were scraped. The area of skin destroyed at this place was 3 inches long by 2 inches wide and communicated with the skin wound on dorsum of foot.

Patient was brought to hospital at once, when he was placed under general anæsthesia, and his wound thoroughly scrubbed with green

soap and bichloride, a counter opening made just above heel and a drainage tube passed directly through ankle joint from outer side backward and wound dressed in wet bichloride. He was then put to bed, and wound dressed every day.

The joint was supported by a right angular splint, which kept the foot in very good position.

September 8th. He suffers a great deal and requires gr. $\frac{1}{2}$ to gr. i of morphine to quiet him, notwithstanding his age.

September 18th. Local condition of foot looks very good, but he has been running. Temperature 105° every day for last four days and mental condition wandering. It looked as though we might have to amputate to save the boy, but after consultation of Drs. Bevan, Chambers and Blake, it was decided to wait a while as the local condition and pulse were good. There has been very little pus at any time.

September 25th. For past few days temperature has not gone above 103° , and general condition somewhat better, but he still requires large quantity of morphine and bromides to keep him quiet.

October 1st. Still doing very nicely. General condition improving.

November 1st. He now runs practically normal temperature and suffers very little pain. Local condition good and very little discharge. Drainage tube removed to-day.

November 15th. Wound over inner malleolus healed, also wound on dorsum of foot. Wound over outer malleolus granulating very nicely.

November 24th. Patient can now bear some weight on left foot and has considerable motion in left ankle joint.

December 1st. Wound over outer malleolus most healed. Patient can walk fairly well without assistance of stick or crutch.

Case III. Service of Dr. J. W. Chambers, City Hospital. S. W., negro, aged 21 years, laborer, American. Family and previous histories unimportant. On afternoon of September 21st, while unloading a column of iron, patient's right hand was caught, destroying the skin on dorsum of wrist for a space $3\frac{1}{2}$ inches by 2 inches, at one point scraping the ulna. On palmar surface the hand was cut from distal extremity of last metacarpal bone, extending diagonally across to

proximal end of first metacarpal bone. This palmar wound was through the superficial and deep fascia and completely dislocated the first metacarpal bone from its articulation with the carpal. Both wounds had a great deal of dirt ground into them, and there was considerable bruising. Patient was brought to City Hospital and was placed under general anæsthetic; hand was scrubbed well with green soap and washed with bichloride, all the dirty and lacerated parts being trimmed off. It was then put up in wet bichloride, and hand placed on splint so as to hold it firmly in position. Hand was dressed every day for first week.

October 1st. Patient had temperature 100° on day following accident, but has been normal since. The palmar wound was partially packed with gauze so as to allow free drainage. Hand is being dressed every other day. There has been very little discharge from wound at any time.

October 15th. All bruised tissue has sloughed, and wound presents a nice granulating surface. Palmar wound has closed up except the place kept open for drainage. Metacarpal bone of thumb seems pretty firm. Patient has suffered very little pain at any time since accident, remaining in bed only one day.

November 1st. Wound still improving and gradually growing smaller.

November 15th. Palmar wound entirely healed, with some motion in thumb and fingers.

December 1st. The wound on dorsum of wrist is still growing smaller; splint has been removed; motion of wrist joint very good. The cicatrix forming on dorsum of wrist seems to be a very healthy one, but should it become unhealthy or produce too much contraction we propose to skin-graft in mass.

In presenting these cases I wish to present the following points of special interest: Amputation was at one time seriously considered in each case. All present open and infected joints, none with fracture, all with considerable damage to soft parts and bony prominences, all with practically no disturbance of circulation of parts beyond injury.

Case I was not placed under general anæsthesia for cleaning for at least 12 hours after injury received, and was followed by profuse

suppuration. Cases II and III were both placed under general anæsthesia within an hour after injury was received, cleaned thoroughly, and was followed by comparatively little pus formation and of course much better joints.

EPIDEMIC (CEREBRO-SPINAL) MENINGITIS WITH REPORT OF THREE CASES.

BY DR. M. SAVAGE, '95.

The disease was not distinguished till the beginning of the present century. It was first recognized as a distinct disease by Vieussien in Geneva, 1805. In 1806 it appeared in Medfield, Mass., and was described by Danielson and Mann. Since, it appeared in different epidemics in various parts of Europe and the United States. Last spring we had a small epidemic in Baltimore. Most of the epidemics have appeared in winter and spring. It generally attacks children and young adults. Sex and race have no influence. One of the predisposing causes is insanitary surroundings and overcrowding.

It is not directly contagious, but it is infectious and is caused by the diplococcus intracellularis meningitidis, often called meningococcus, and found in the purulent exudate of the meninges; they occur singly, or in groups similar in arrangement to gonococci, enclosed in white corpuscles.

The organisms grows in agar-agar, the pure cultures forming a white, rather vivid growth; both in cultures and in tissues they are discolored by Gram's iodine solution. They grow in most cultivation media provided they are not acid. Councilman found the diplococci in 90 per cent. of the postmortems, either in culture or microscopic examination of the exudation. He performed lumbar puncture in 55 cases and made cultures from the fluid withdrawn; in 35 cases he found the diplococcus. The organism has also been found by other observers. In 1893 Flexner and Barker, of the Johns Hopkins Hospital, found the lanceolate diplococci in the meningeal exudation, both free and enclosed in their cells, in an epidemic at Lonaconing, Maryland. Lumbar puncture was made in nine cases treated at the above Hospital

last spring and in two cases undergoing treatment at present; in each instance was the meningococcus found. The pathology consists essentially in an acute purulent inflammation of the pia and anachnoid, both of the brain and cord. In the brain the effusion may be distributed either at the base or at the convexity. The changes are most pronounced along the larger blood-vessels and in the fissures of the cortex. In the cord the posterior aspect is mostly affected, especially in the lumbar region.

The mode of infection is not known as yet. It has not been traced to food or water-supply. The manner of spreading is very capricious; there are no apparent connecting links between the epidemic of one locality and another. It is endemic in certain places; sporadic cases often occur before or after an epidemic. According to Councilman the mortality is about 68 per cent. The question of immunity is not yet settled.

Symptoms and course.—There may be prodromata, such as chills, headache, malaise, pain in the back and limbs. More often they are absent; it begins then abruptly with chilliness or rigor, headache, pain and stiffness in the back of the neck, often retraction of the head, less often opisthotonos. Another important symptom is severe vomiting, which is of cerebral origin, independent of any food. There may be even at the beginning severe mental disturbance, such as stupor or delirium passing into mania. Later on these symptoms continue with great irregularity. The disease may in severe cases, "malignant type," lead to a fatal termination in a few days.

There are also "abortive cases," in which the symptoms are of a mild degree, and lasting only from a few days to a week. A third type is the "intermittent type," in which there are alternate remissions and exacerbations of the symptoms. The average duration is from three to four weeks. The temperature generally does not run high, 101 to 104 being the average temperature; it runs an irregular course, and is not necessarily in conformity with the gravity of the disease; it is remittent or intermittent, as well as there are intermissions of the symptoms. There may be hyperpyrexia before death. The pulse is not characteristic, it is compressible and of low pressure. Respiration is not quickened, but it may be embarrassed, due to pain caused by

its movements. The bowels are usually confined. The face is pale, the expression often anxious, indicative of pain. The patients are often very restless and irritable. The urine sometimes contains albumin, the quantity of chlorides diminished. The blood shows marked leucocytosis (Flexner and Barker). The headache is intense, often intolerable, more localized at the occiput and back of the neck. The pain radiates down the spinal column, which is often extremely tender, to the limbs and abdomen. The abdominal pain is often persistent. The pain is aggravated by all movements. Frequently there is cutaneous hyperæsthesia, or hyperalgia, probably originating in the irritation of the sensory nerve-roots. Retraction of the head is almost pathognomonic. Besides the opisthotonos already mentioned, there may be rigidity of the limbs, or flexor contractions, or risus sardonicus, or even trismus. There may be distressing vertigo, especially experienced by the patient upon lifting the head from the pillow. In most of the severe cases intelligence is blunted; there may be delirium, or the opposite, slight drowsiness or even deep coma. Sometimes twitching of the limbs occurs; prolonged convulsions are met with in grave cases. Disturbance of the cerebral nerves is common. There may be paralysis of the ocular nerves, causing squint, ptosis, nystagmus, sluggishness, dilatations and inequalities of the pupils, unilateral or bilateral; there may be contraction of the muscles of the face, or even facial paralysis. Changes in the nerves of special senses often occur, such as earache or tinnitus; there may be a purulent inflammation of the labyrinth, or an otitis media causing deafness. Optic neuritis was found by Dr. Randolph at Lonaconing, Maryland, six times in forty cases.

One of the most common cutaneous affections is herpes of the face and lips, commonly occurring within the first week of the illness; there may be erythema, roseola, urticaria or petechiæ. There may be pulmonary and bronchial symptoms.

The treatment must be symptomatic as we have no specific. Ice bags upon the head and along the spine; some authors recommend depletive measures at the beginning of the disease, such as leeches behind the ears and cupping on the back of the neck and along the back. Calomel, best in small doses frequently repeated, morphine to

relieve the pain and restlessness and to procure sleep; for the same purpose chloral and potassium bromide may also be used. As an absorbent, potassium iodide may be given; this drug is supposed to be valuable, particularly in tedious cases during the later part of the disease. To reduce the fever sponging is best—baths cause too much suffering by the manipulations. Complications require special treatment. Local paralysis is to be treated by massage and electricity.

Case I. Th. L., aged 12 years, school-boy. Mother died of septicaemia, father living and in good health; he has three brothers and three sisters, all of them healthy. Has never had any serious illness. On Monday (May 23rd) patient was very drowsy and ate very little for breakfast; while at school in the morning of the same day he was suddenly taken with a chill and severe headache. After returning home from school, he became very feverish and vomited several times. On the following day he became restless and delirious and had to be held in bed. He was admitted to the City Hospital May 27th; his temperature was then 102° , pulse 65, was delirious, neck very much retracted, face pale, bearing a languid expression of pain, marked general hyperaesthesia, patient crying when slightly jarred, slight attack of herpes facialis, tongue moist and thickly furred, patient extremely thirsty. Respiration not disturbed, pupils dilated, bowels constipated. He was much emaciated.

During the first week after his admission the patient appeared to be slightly improved until June 4th, when his temperature went up to 103 , and became very restless. From this date until the 18th the temperature ranged between 99 and 104 with intermission and irregularities. Bowels constipated unless opened by laxatives or enema. Ice has been applied constantly.

June 22nd. Patient much improved, temperature 99, has had two stools without an enema.

26th. Patient delirious, temperature $100\frac{1}{5}$, pulse 103.

27th. Still delirious and very restless; temperature $101\frac{4}{5}$, pulse 95, and very weak.

28th (9 A. M.). Patient gasping for breath. Temperature $102\frac{2}{5}$, pulse 105, and hardly perceptible. On the same day about noon he died.

Case II. Rose K., aged six years. Father died of pulmonary tuberculosis, mother living. On May 12th patient complained of headache and pain in back. On the following day she vomited repeatedly, and there was stiffness of the neck, a temperature of 102 and pulse 100. The next day there was considerable retraction of the head, and suffered greatly from pain in head and abdomen and general hyperæsthesia. At the end of the week the pupils were dilated and sluggish. The bowels were opened by small doses of calomel, and antipyrin given in one and a half grain doses every 3 hours.

During the following two weeks the temperature fluctuated between 101 and 104; at times she was delirious and very restless, at times semi-comatose; she screamed whenever moved to change the bed cloth, no matter how gently handled.

June 3rd. Pupils much dilated and did not react to light. Patient was much emaciated; whenever her mind was clear she complained of pain in the head and abdomen, later on also of earache, which proved to be an attack of suppurative otitis media. She had a stomatitis and sordes, and developed a conjunctivitis with a muco-purulent discharge during the fifth week of her illness. She was given potassium iodide and sodium bromide, each one grain every 3 or 4 hours, and paregoric to relieve the pain in the head and abdomen.

June 10th. Patient, whilst very weak and emaciated, has had no temperature for three days, the rigidity of the neck is hardly noticeable, there is some contraction of the pupils to light; the conjunctivitis was treated by mild astringents, and the otitis by injections of a hot solution of boracic acid into the ears. The patient was slowly recovering until the end of the month, when she was up and about, perfectly free from the complications.

Case III. Benno C., aged seven years. On May 30th the patient had a headache, pain in his limbs preceded by a slight chill, and complained of sore throat. His temperature was 103, pulse 110, tonsils and pharynx congested. These signs and symptoms led the writer to believe that the boy had merely a cold. On the following day the patient vomited persistently, and there was considerable stiffness of his neck, thus revealing the nature of the trouble.

On June 1st the head was very much retracted, his temperature

was 103, was delirious and markedly hyperæsthetic, his pupils were dilated and sluggish. Besides the application of cold to the head and back, the small doses of calomel and antipyrin which were given as in the previous case, he was blistered with cantharides plaster at the nape of the neck. A large blister formed on the next day with considerable relief of the symptoms. This condition lasted about five days, when the patient began quickly to recover. As in the other case, potassium iodide and sodium bromide, one grain of each, were given every 3 or 4 hours.

THE TREATMENT OF GONORRHEA.

By DR. W. L. CHAMPION, '91.

In this day and time, with the advancements that have been made in medicine and surgery, the above question to some men would seem foolish. But when we examine the patients that come to our office, note the treatment they have had, the number of hands they have passed through, the duration of the attack, the results from the treatment, and the serious train of troubles that follow the disease, any physician that has gonorrhoea to treat will ask himself this question.

Of all curable diseases known to mankind gonorrhoea is considered the most unsatisfactory to treat. In a large percentage of the cases we treat in the male, when the discharge stops, without taking the physician's advice, they consider themselves well and take a spin on the bicycle, take a few drinks of whiskey or stay with a woman, and the last condition is worse than the first. Gonorrhoea is looked upon too lightly by the laity, and I am sorry to say, also by too many physicians. It is not only the number of attacks of the disease that produce serious sequelae, but the duration of any one attack. Take the ordinary run of patients, and when they contract the disease they meet a friend who has a certain cure in the shape of an injection; this fails, and they try the balsams; this fails, and they try the druggist; the druggist fails, and they seek the doctor; by this time the disease has become chronic and conditions are present that prolong the treatment.

When the majority of physicians see a gonorrhoea in its incipency

they write a prescription for the patient and tell him to return in a few days; the patient returns with the discharge and is told to continue the treatment and return again in a few days; he follows directions and returns again, and the prescription is changed. This is continued for weeks and sometimes months, until the discharge stops or the patient changes doctor instead of prescription.

These are the cases that produce stricture, cystitis, prostatitis, seminal vesiculitis, and various other serious conditions.

Within the past few months Dr. J. A. Childs and I have treated about fifty cases of the disease, a few of them being chronic, and have secured excellent results in all, and did not prescribe an injection or any medicine internally except in two or three cases where it was impossible for the patient to come to the office. The conclusion I have come to is that the only rational treatment for gonorrhoea is by irrigation. Whether you use bichloride of mercury, boracic acid, nitrate of silver, permanganate of potash, alum or any other antiseptic or astringent, it is the treatment. Usually in from seven to ten days you can stop the discharge, reduce the swelling and make the patient comfortable.

A graduated glass fountain syringe that will hold half a gallon raised twelve or eighteen inches above the head, so as to give some force to the current, is best. This and a soft rubber catheter are all the apparatus needed. The catheter should be large enough to comfortably fill the urethra (18 to 20 French), if the meatus will admit, so that the folds of urethra are smoothed out, and the solution will come in contact with the entire surface. Of the drugs used my preference is boric acid or permanganate of potash. The strength of the various solutions used must vary according to the condition of the urethra. A saturated solution of boric acid can be used in any case. With the potassium permanganate we should commence with 1 part to 6000 of water; as tolerance is established, increase the strength until 1 to 1000 is used. We have found that 1 to 30,000 bichloride of mercury is very painful in some cases, and not as good as the above solutions. The solution used should be of a temperature of 110 to 115. For the first few days only irrigate the anterior urethra, passing the catheter to the cut-off muscle, and after that fill the bladder and allow the

patient to pass it out through the urethra. The catheter should be passed up very slowly so as to thoroughly wash out the urethra and not carry any of the poison into the bladder. When the catheter is passed up properly there is no danger of forcing gonococci into the bladder, as some think; as the catheter passes up the urethra the current is turned on and all the accumulation in the canal is washed out. The irrigation must be kept up twice a day until the discharge stops, then once a day for a week or ten days, and after that every other day for several days. There is usually no trouble to get patients to come to the office twice a day, as it takes very little time and they are soon convinced that it is the proper way to treat the disease. If there is a granular patch in the urethra an application through the endoscope in conjunction with the irrigation will hasten the cure. If the urethra is narrowed at any point and if necessary to dilate with the sound, use as a lubricant for the instrument glycerine, and irrigate after passing it with hot solution of boric acid, and it will lessen the chance for a urethral chill and also the discharge we usually see after passing an instrument. In a posterior urethritis an injection through an ordinary penis syringe does not reach the seat of inflammation, but passing the solution through a catheter, it comes in contact with the entire inflamed area. For injections of nitrate of silver in a posterior urethritis or inflammation at the neck of the bladder the catheter is better than any deep injection syringe. Of the fifty cases treated, there were only three cases with complications; two of these were epididymitis, and one prostatitis. The cases with irritation at the neck of the bladder were promptly relieved with solution of nitrate of silver from 1 to 4000 to 1 to 2000. By the irrigation plan of treatment you can shorten the disease, lessen complications and serious after-effects.

REPORT OF A CASE OF CASTRATION.

BY DR. THOS. A. COUNCELL, '94, EASTON, MD.

At the request of Dr. J. B. Merritt, attending physician at the Talbot County Almshouse, I visited the institution with him for the purpose of examining the case below recorded. The history obtained was as follows:

Lacy W., colored, age 18, single, mother dead, no father known to be living; has been in institution for five or six years. Diagnosis, idiot.

This much could be obtained from superintendent, but no further history previous to entrance was known. For past three years he has apparently grown worse—could understand commands far less easily, and during past six months has become so he could not speak distinctly.

A pronounced athetosis existed, and this was especially so of the muscles of the neck and right arm and hand; the shoulder-joint would at times show distinct subluxation, fingers hyper-extended and other marked symptoms. He was hearty and strong, and had not needed the physician for any acute illness since his reception.

Mentally his condition was not improved, and if anything more grave; he was an inveterate masturbator and had recently made several attempts at rape upon the female patients and attendants connected with the almshouse. This latter freak on his part had caused the board of trustees to look into the matter and requested the consultation above referred to.

Talbot County is no exception to the rule, and I am sorry to record that the facilities of sufficient attendants and proper isolation are sadly needed at this institution; and as a result of not being able to carry out a proper isolation and careful watch, castration was decided upon.

On May 16th the operation was performed by the writer, being assisted by Dr. J. B. Merritt, the almshouse physician, and three students. The patient's bowels had been thoroughly moved the night before, and the pubes shaved and thoroughly scrubbed with soap and water, and later with a 1-2000 bichlorid of mercury solution. They were then wrapped in a 500 per cent bichlorid gauze. Much trouble was experienced in placing our patient under the anæsthetic, ether being used, it being preferred by the anæsthetizer.

The incision was made from a point about an inch below the external ring to the bottom of the scrotum. This was gradually deepened until the tunic was reached. The testicle was here freed from its attachments, except the cord, by handle of scalpel. The cord was then drawn down and clamped. The blood-vessels were ligated sep-

arately and the cord was allowed to retreat in the canal. Was extremely cautious to prevent all oozing before closing wound. No drainage tube used, but wound closed with interrupted suture. The same technique was used on both testicles. The scrotum was elevated and dry dressing of iodoform gauze was applied. Patient recovered from anæsthetic in half-hour.

Following day temperature was 99, and on second day dropped to 98.4, and no other rise was recorded. Stitches were removed on 8th day and patient allowed some liberty. Recovery from operation complete. Since operation he has greatly improved both mentally and morally. Has made no attempt to molest any of the females of the place, and attendants say he has not attempted masturbation. The nervous trouble has subsided wonderfully, and the marked athetosis has almost entirely disappeared in hand and arm.

REPORT OF A CASE OF OPIUM POISONING.

BY DR. H. W. STRADER, '85.

At 10.10 P. M. was hurriedly called to see a man supposed to be dying. Found him lying on a bed, undressed, unconscious, mouth open, tongue dry and parched, breath offensive, odor of decomposed food. Respiration ten per minute, labored and stertorous, pulse full and steady, pupils contracted to a point. A diagnosis of opium poisoning was made. I gave hypodermatically 1-25 gr. sul. atropia and 1-15 gr. of sul. strychnine at once. The stomach was thoroughly irrigated with the ordinary tube, using about 8 gallons of water at a temperature of 100 F.

There being no perceptible change 45 minutes after giving first dose of atropia and strychnine, it was repeated; soon there was a slight improvement in respiration. Then I gave hypodermatically a solution of pot. permang., using about 3 grs. well diluted. Later in the case used smaller doses of atropia and strychnine. Consciousness returned about 8.30 A. M., 16 hours after taking the dose. Patient said he had procured 25 cents worth of morphine at a drug-store and had taken same between 4 and 5 P. M.

My observations of this and other cases lead me to the following conclusions in the management of these cases:

1st. That it is almost impossible to make a mistake in diagnosis.

2nd. That as death results by a paralysis of respiration, we have in atropia a remedy of much value.

3rd. That strychnine in large doses increases the action of atropia.

4th. That the stomach should be vacuated promptly in all cases. Apomorphia should be used, owing to its well known depressing effects.

5th. That pot. permang. decomposes morphine and should be given in solution hypodermatically.

6th. That flagellation, irritants and rough treatment are absolutely useless.

530 K Street, Sacramento, Cal.

A CASE OF FOREIGN MATTER IMPACTED IN THE RECTUM.

BY DR. W. C. McCURDY, '74.

About September 14th I was hurriedly called to see Mr. E. H., 30 years old, who three days previously had eaten a quantity of small crabs together with shells of same. I found him face down on the outer steps of house, his nates exposed, piteously moaning with pain. I asked him what was his trouble. He replied that he had eaten a lot of crobs, shells and guts, and they had got as far through as his anus and stopped, and if I could not get them out he would be a dead man in two hours. A further examination on my part revealed a protruding rectum and sufficiently dilated to disclose a mass of chopped-up crab shells and stercoraceous matter. I at once made an effort to remove the mass with my finger but the parts were so tender from the lacerated condition that this process had to be abandoned. I thereupon dispatched a messenger for my friend Dr. Smithson, who arrived some four hours later. After a brief consultation we gave chloroform, and I removed with a dull curette one and one-half pints of shells, fecal matter and stinking mucus. After washing the bowel with carbol-

ized water and giving him a tablespoonful of oil I left him with instructions to retain all alvine evacuations for my inspection next day. On my return I found quite a quantity of debris with slight rise of temperature. However, the patient made a good recovery. I do not mention this because of any great skill required in the case, but because of the oddity of the man eating crab shells in a land overflowing with milk and honey.

SPINA BIFIDA—A CURE BY IODINE INJECTIONS.

BY DR. S. WALTER WOODYARD, '91.

In the latter part of February of the present year, I was called to see Willie M., æt. two months. I was informed that the child had a tumor in the lumbo-sacral region of the spine, and that the midwife in attendance wanted to poultice the same.

I found that I had a spina bifida to deal with. At this time the tumor was about the size of a goose egg, sessile, translucent, and fluctuating; all the skin covering the tumor except a place in the centre about the size of a ten-cent piece was in good condition. When the child cried, the tumor would bulge out and become tense.

In treating this case, conservative methods were employed for a few weeks, until the patient was in good condition, when Dr. J. R. Boyd, '93, of Oakvale, W. Va., was called in consultation. As the tumor was growing rapidly, and from all indications would soon rupture, we decided to use iodine injections, thinking we would give our patient a chance at least for its life. Accordingly, we aspirated one drachm of fluid from the tumor, and immediately injected into the tumor one drachm of—

R—Iodinigr. x.
 Potassi iodidigr. xxx.
 Glycerini, C. P.3i. Mix.

Following this injection, a slight degree of coma was manifest, which lasted about twenty-four hours. The tumor became slightly inflamed for a day or two; after this, there were no effects of the treatment appreciable. At the expiration of one week, the same treatment was repeated. No coma was shown; the tumor became inflamed

within twenty-four hours; the patient was very restless, and refused to nurse. From this time on, the skin became wrinkled, and the tumor began to diminish in size, and at the end of the third week it had almost entirely disappeared. Nothing remained but a bursa about the size of a twenty-five cent piece. The patient is now in good condition.

Greenville, Tenn.

DR. WILLIAM S. GARDNER, '85, in a paper upon "The Relation of Albuminuria to Puerperal Eclampsia," makes the following statements: In a series of 180 consecutive cases, $5\frac{1}{2}$ per cent. were shown to have albumin in their urine before labor, and more than 12 per cent. of them the first day after labor. Included in this series were four patients who were attacked by convulsions. Of the four, in only one case was the presence of albumin detected before labor; in three cases there was a large quantity of albumin present soon after the convulsions; in one case there was never any albumin present, and in one there was no albumin present twenty-four hours after convulsions.

Elliott records eleven well-marked cases of albuminuria, only four of which had convulsions; and, on the other hand, there were six cases of convulsions where the urine was examined, but no albumin and no other signs of kidney lesions were discovered before the appearance of the convulsions.

If we add these to the ones already related we have a total of fifteen cases of puerperal convulsions. The urine from each case was analyzed before the convulsions appeared. Albumin was found six times, and it was not found nine times.

1. The presence of albumin in the urine of a pregnant woman is no sufficient cause upon which to base a prognosis of probable eclampsia.

2. The failure to find albumin in the urine of a pregnant woman is no evidence of the absence, or at least, of the continuance of the absence of the condition that gives rise to puerperal convulsions.

3. Albumin is so frequently found in considerable quantities in the urine of patients immediately after the appearance of puerperal convulsions, that we are justified in making the statement that the convulsions are the probable cause of the albuminuria.

Practical Ureanalysis and Urinary Diagnosis: A Manual for the Use of Physicians, Surgeons, and Students. By Charles W. Purdy, M. D., LL. D. (Queen's University). Fourth revised edition. With numerous illustrations, including photo-engravings and colored plates. In one crown octavo volume, 365 pages, bound in extra cloth, \$2.50 net. The F. A. Davis Co., publishers, 1914-16 Cherry St., Philadelphia; 117 W. Forty-second St., New York City; 9 Lakeside Building, 218-220 S. Clark St., Chicago, Ill.

To him who would know the valuable facts to be learned from a complete and accurate chemical and microscopical examination of the urine this book is heartily recommended. This is not a mere compilation, as so many of our text-books are, but bears the stamp of a man who knows both ureanalysis and English.

The manner of preparing the reagents and the methods of applying them in the chemical tests are so clear that any one even with a very limited knowledge of chemistry can use them accurately. The plates showing the urinary sediments are excellent. In an appendix is given an able presentation of the methods that have been found most practical in examination of the urine for life insurance.

A Primer of Psychology and Mental Disease for Use in Training-schools for Attendants and Nurses and in Medical Classes. By C. B. Burr, M. D. Second edition, thoroughly revised. $5\frac{1}{2} \times 7\frac{3}{4}$ inches. Pages ix-116. Extra cloth, \$1.00 net. The F. A. Davis Co., publishers, 1914-16 Cherry St., Philadelphia; 117 W. Forty-second St., New York City; 9 Lakeside Building, 218-220 S. Clark St., Chicago, Ill.

The second edition of this most excellent little volume is just out. It is concise. It abounds in common sense. It gives the beginner descriptions of the ordinary forms of insanity and clear directions as to the most rational methods of caring for patients so affected. Every medical student should have a copy of this book. It will get him started right.

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THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

NEUROSES OF RETROFLEXION.

The intra-pelvic condition that most frequently gives rise to marked disturbance of the nervous system is retroflexion of the uterus. Patients suffering from this condition sometimes have such marked and persistent nervous symptoms that they are commonly called hysterical. But they do not have hysteria in the acceptation of what the word hysteria implies as it is used at the present time. They do have hysteria in the true etymological sense of the word, that is, a series of manifestations of a disturbed nervous system that are due directly to a uterine lesion.

In the cases coming under my own observation the extreme nervous symptoms are most commonly associated with extreme retroflexion without adhesions.

The symptoms are variable. Some patients will have frequent convulsions, ordinarily called hysterical convulsions; some have palpitation of the heart; are easily frightened; cry or laugh upon very slight provocation; some develop an irritable temper so that they make themselves and their associates continuously uncomfortable; others say that they are afraid that if they are not relieved they will become insane. Not infrequently these nervous symptoms mask the local symptoms so completely that the lesion is overlooked.

Too often these patients are plied with bromides, or treated by

suggestion, or not treated at all. The gross injustice done these patients is the more marked when we remember that every one of them can be cured by bringing the uterus into its proper position and keeping it there either by a pessary or a ventral suspension. In the more severe cases, even where there are no adhesions, the ventral suspension is the better procedure.

W. S. G.

At the spring meeting of the Maryland State Board of Medical Examiners 90 per cent of the graduates of the College of Physicians and Surgeons passed—the highest percentage of men from any school represented. The highest individual mark made, 93.6 per cent, was made by a College man. The average rating for P. & S. men was 80.9 per cent, which was the highest average made by men from any school. These are the kind of figures that speak in the highest terms of the quality of the work done both by students and instructors.

We would be glad to have every man who has any intention of attending the Commencement Exercises in April send his name to the JOURNAL before the first of March. In the April number these names will be published and many from out of town will know who are to be here and will make it a point to come in and meet them. A few weeks ago a couple of the boys from other States came to the city and met at the Eutaw House for the sole purpose of talking over the old school days. There are many who are just as enthusiastic. Let us all get together in April and have a good time. We will secure a reserved seat at the Commencement for all who notify us in time to do so.

Personal Notes.

DR. V. L. TODD, '90, is Professor of Chemistry and Toxicology in the Columbian Medical College of Kansas City, Mo.

DR. E. J. RUSSELL, '97, has returned to Baltimore after three months spent as acting assistant surgeon in the army.

DR. THOS. C. SCUDDER, '95, is acting assistant surgeon in the Eighth Regular Cavalry and has gone to Cuba with that regiment.

DR. N. T. CARSWELL, '86, is located at 654 Cherry St., Macon, Ga., and has recently done three successful vaginal hysterectomies.

DR. G. C. THIEME, '96, was in the volunteer service three months. He spent almost the entire time at the hospital of the First Division, Fourth Army Corps, at Huntsville.

DR. N. G. KEIRLE, of the faculty, who has charge of the Pasteur Department of the College, wrote the article on Rabies for the fifteenth volume of the Twentieth Century Practice of Medicine.

DR. R. PERCY SMITH, '91, is located at Sunnybrook, Md. He is examiner for several large life insurance companies, is vice-president of the Baltimore County Medical Association and enjoys a lucrative practice.

DR. JULIUS FRIEDENWALD, '90, has just concluded some experimental studies with eudoxine, and says he has had excellent results. An abstract of the paper will be published in a future issue of the JOURNAL.

DR. J. S. ARNOLD, '96, has been located in Washington, D. C., for the past two years. He is located only one square from the new Congressional Library building. He has succeeded in building up a paying practice.

DR. A. T. SPROESSER, '84, of Chicago, Ill., sent us the names of twenty-four alumni whose addresses had been lost. If a few more would show a like interest our list would soon be complete. Another alumnus has sent the complete list of alumni practicing in Nova Scotia. Such work is highly appreciated.

DR. ALAN W. SMITH, '95, was for three years assistant quarantine physician at the port of Baltimore under Dr. Sydney O. Heiskell, '82. Upon leaving that position he pursued his studies abroad for several

months and upon his return he was appointed assistant surgeon in the marine hospital service of the United States and is now located at Fort Monroe in charge of the quarantine ship Jamestown.

DR. THOS. F. BLACK, '90, of Providence, R. I., says in a recent letter: "I receive the Quarterly and enjoy very much reading of old chums; but why not more of the class of '90? What has become of S. G. Evans?" Let some of the other boys of '90 be heard from.

The alumni are well represented in the faculty of the College of Physicians and Surgeons, Kansas City, Kan. Dr. E. M. Hetherington, '88, is Professor of Obstetrics; Dr. Z. Nason, '88, is Professor of Dermatology, and Dr. J. E. Sawtell, '86, is Lecturer on Diseases of the Nose, Throat and Chest.

Some addresses were asked for in the JOURNAL of the A. A. of the C. P. & S. for October. It may interest some to know the addresses of the following alumni who are located in Nova Scotia, Canada: W. J. Barton, '96, Pubnico, Yarmouth Co.; O. H. Cameron, '92, Maccan, Cumberland Co.; A. W. Chisholm, '94, Margaree Forks, Inverness Co.; H. S. Densmore, '92, Elmsdale, Hants Co.; F. S. L. Ford, '94, New Germany, Lunenburg Co.; J. A. M. Hemmeon, '96, Bridgewater, Lunenburg Co.; A. E. Kennedy, '93, Mabou, Inverness Co.; D. A. Morrison, '93, Louisburg, C. B.; J. D. Mosher, '86, Rawdon, Hants Co.; Dan. MacDonald, '92, Baddeck, C. B.; A. A. Schaffner, '94; Lawrencetown, Annapolis Co.; C. M. Weeks, '91, Newport, Hants Co.; Edward Jeffers, '97, Parrsboro, Cumberland Co.; J. C. Feindel, '97, New Germany, Lunenburg Co.; J. A. Payzant, '84, Burlington, Hants Co.; L. R. Schaffner, '93, practiced a year in Ravenna, Nebraska. He returned to Boston, Mass., the following year and died under an operation at the Massachusetts General Hospital in August, 1894.

WESTCHESTER, N. Y. CITY, December 10, 1898.

Dear Dr. Todd.—I regret very much that I cannot send the promised paper for this issue of the JOURNAL. My time has been and is

still so fully occupied that I cannot finish the paper at present. However, hope to have it ready for the next issue.

Enclosed find check for \$3.00 for three subscriptions—names on another sheet.

If you will furnish me with a list of your N. Y. State subscribers I may be able to reach and secure some others not now subscribers.

I would like very much a list of the names of graduating class of 1891. Mine was lost. Can you secure such a list for me?

The names to receive the JOURNAL are as follows: Dr. H. Illaway, 1138 Madison Ave., N. Y. City; Dr. Geo. Place Clements, 121 East 106th St., N. Y. City; Dr. Thos. Wight, Andes, Del. Co., N. Y.

Wishing you continued success,

Sincerely,

J. GORSE SIMMONS, '91.

PUNXSUTAWNEY, PA., October 11th, 1898.

PROF. WILLIAM GARDNER, M. D., College of Physicians and Surgeons,
Baltimore, Md. *

My dear Gardner.—I enclose you one dollar for the Alumni JOURNAL for the following year. I note, in the last issue, you inquire the whereabouts of Dr. C. H. Haning, '94. Immediately after his graduation the doctor came to us here at our Adrian Hospital, where for two years he gave excellent satisfaction as Resident Physician. For the last 18 months he has been in Cleveland, Ohio, where he opened up an office and is building up a profitable practice.

Hoping to be with you at the next alumni meeting,

Very truly yours,

W. S. BLAISDELL, '90.

FREMONT, N. C., September 5th, 1898.

DR. WILLIAM J. TODD, Baltimore, Md.

Dear Doctor.—You will find enclosed my subscription and one dollar for the Journal of the Alumni Association of C. P. & S.

I graduated in the class of '94, and have been practicing here, at

Fremont, since, and have done fairly well I think. I am doing a general practice, a country practice mostly. I see notes from some of my classmates in the last number of the JOURNAL and would like to hear from others through the JOURNAL. May the JOURNAL prove a success.

Respectfully,

W. T. TURLINGTON, '94.

SYRACUSE, S. C., October 18, 1898.

DR. WM. J. TODD, Baltimore, Md.

Dear Doctor.—The JOURNAL of the Alumni Association of the College of Physicians and Surgeons for October received, the first number I have seen. We notice among the names of gentlemen of whom you ask information is that of Dr. Jas. O. Byrd. My lamented friend and preceptor died October 13th, 1895, at his residence in Timmons ville, S. C. He was several times elected to the S. C. Legislature and was a member of that assembly at the time of his death. He was a friend, kind and generous to a fault. In his death the profession has lost a shining light—the poor, a friend indeed.

Success to the JOURNAL.

I graduated from College of P. & S., 1879. Have an elegant farm and country residence and a goodly share of practice.

Fraternally,

J. P. PARROTT, M. D., '79.

BUCKINGHAM, VA., July 9, 1898.

DR. WILLIAM J. TODD, Baltimore, Md.

Dear Sir.—It was with a feeling of very great satisfaction of a long-felt want having been filled when I read the first number of the JOURNAL. The pleasure was much increased to learn of the whereabouts of members of my own class, '96, whose memory is still as fresh to-day as when we said good-bye after the commencement. I have been here in Buckingham since I passed the State Board. My practice is large both in extent of area and number of patients. My success has been very satisfactory to me so far, and my practice is still on the increase.

I want to second Dr. Priddy's wish as to your writing up the classes. I am sure all of us would enjoy such numbers, whether it should be of our class or of another.

Wishing you much success, both personally and with the JOURNAL,
I am

Sincerely yours,

J. BURTON NOWLIN, M. D.,
Class '96.

SIDE-LIGHTS ON ARMY LIFE DURING OUR LATE UNPLEASANTNESS; CULLED FROM THE LETTERS OF MR. CHAS. J. HALPER.

BY CHAS. E. BRACK, M. D.

"Wenn Einer eine Reise macht
So kann er was erzählen."

There has been so much written and said about the conditions existing in many of the camps, concerning rations, treatment of soldiers and conduct of officers in charge, that we are led to believe that the conditions to which the men were subjected were unbearable and beyond human endurance.

It is truly refreshing then to read the correspondence of one who is gifted with an indestructible sense of humor, one who has the enviable faculty of seeing the bright side of things and who is philosopher enough to take things as they are and make the best of them.

Mr. Halper enlisted as a private in the 5th regiment at Camp Wilmer, went to Chickamauga and Tampa with the regiment and was then transferred to the hospital corps at Fernandina.

YOUNG MEN'S CHRISTIAN ASSOCIATION TENT AT CAMP WILMER.—Thanks for the razor. I was on guard duty to-day from 9 A. M. to 11 A. M. and in consequence feel rather rocky. The feed is all right, but I eat pork three times a day or starve; there are others. By the way, we were paid off to-day, and in consequence the entire camp was full—of visitors.

If we were ducks with web feet we would feel very much at home.

The major found out to-day what the hospital call meant and appeared surprised that there was something for him to do.

I shall write to one of you once a week.

CHICKAMAUGA.—Well! here we are, living on the fat of the land, for I never saw so much fat in my life. We have bacon morning, noon and night, and when we go to sleep we have snakes. Not the kind some of the boys see at times, but the real thing, seven and eight feet long; they have not the least respect for one, and I have waked up several times during the night and found them crawling over me.

One man said he thought that he had seen all varieties of snakes and bugs when he had delirium tremens, but there were more here than he had ever seen in that condition.

We do not enjoy the luxury of a board floor as at Pimlico. There is as much difference between Chickamauga and Pimlico as there is between a free lunch and a dinner at the Stafford.

I am every inch a soldier lad, as the story goes, but I wish I had been a few inches shorter when I enlisted.

We have been having skirmish drills from 7 to 9.30 and from 3 to 5; dress parade at 6.30; but we are still living and happy.

They will have a nice lot of cleared ground for building lots when we get through with it.

Talk about your summer excursions; if I am not getting it who is?

Last night I received from home a hundred cigars, which I divided among the boys to make myself as solid as the Washington monument; also a lot of canned goods, and last, not least, \$5.00 in cold cash. I hied myself at once to the Missouri canteen and deposited the V. Then I came home in company of two lieutenants and now I am afraid to brush my teeth or eat lest I lose the flavor. Heaven knows when I will get another.

Beer is not so plentiful as in Baltimore, or in other words "the banks are on the ocean."

Thank goodness! I have only 23 months, 1 week and 6 days more to serve. After that I will be made colonel of a militia regiment, join the grand army, and draw a pension.

I hear an old familiar voice yelling in the distance, "Fall in, B," and like all great men I take a fall. We leave here Thursday, so the orders were read to us this morning; whether for better or worse is more than your humble servant can tell.

Continue to use Parke, Davis & Co.'s Anti-Diphtheritic Serum. We continue to lead in potency, efficiency and reliability of product. Remember also that P., D. & Co.'s Serum is marketed in hermetically sealed bulbs (not ordinary vials and corks), which exclude the air and keep the serum strictly aseptic.

Latest literature mailed upon request.

Special Notice.—The validity of the recent patent issued by the U. S. Patent Office on diphtheria antitoxin will be contested in the courts. Pending a decision in the case, we beg to announce that we shall, at our own expense, protect and defend physicians in any legal proceedings which may be brought as a result of the purchase of "P., D. & Co.'s" Anti-Diphtheritic Serum. Order it at any time and in any quantity without hesitation.

Parke, Davis & Co.,

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GEORGE H. ROHE, M. D., Professor of Materia Medica.

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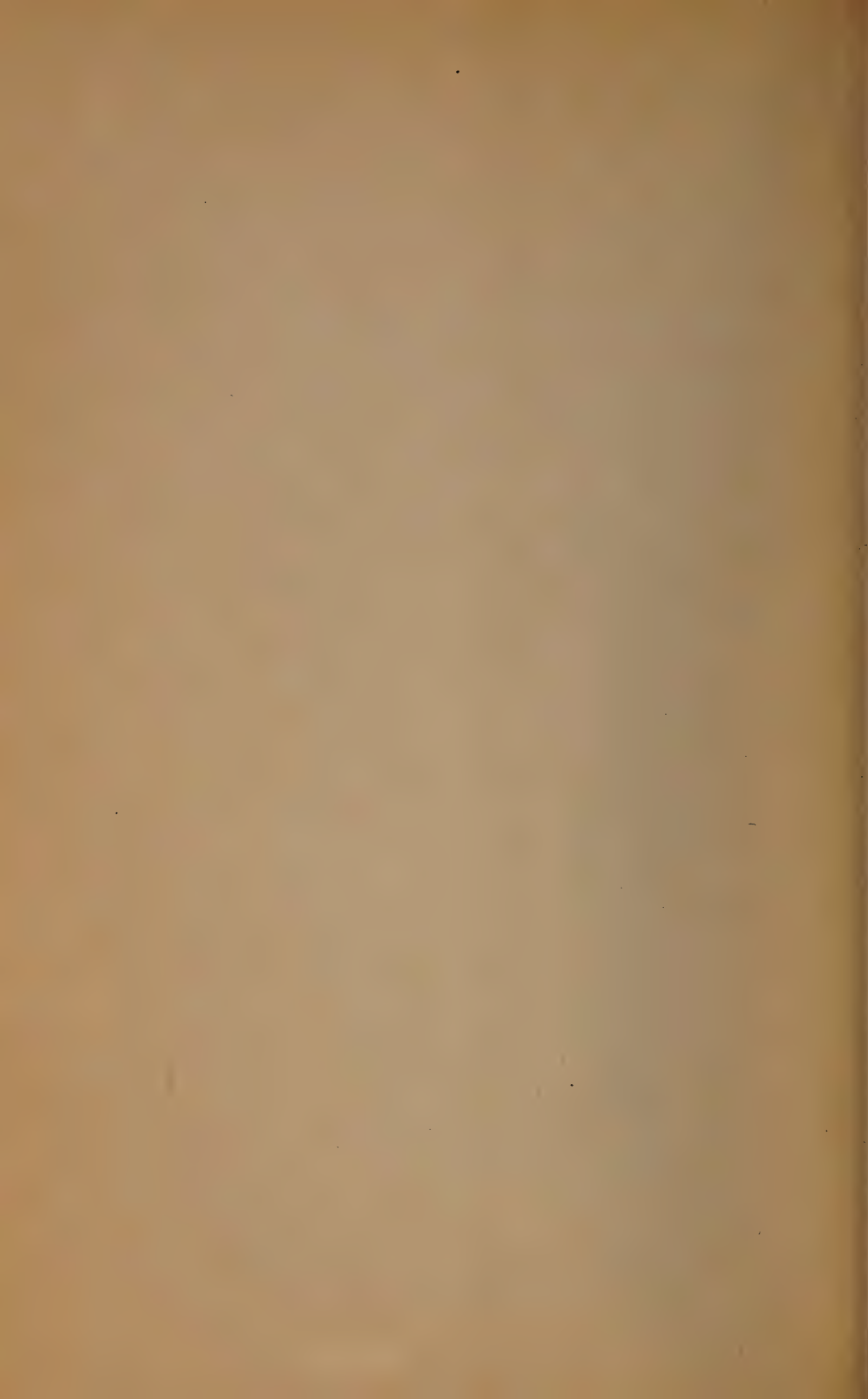
BALTIMORE.

Vol. II

No. I

APRIL, 1899

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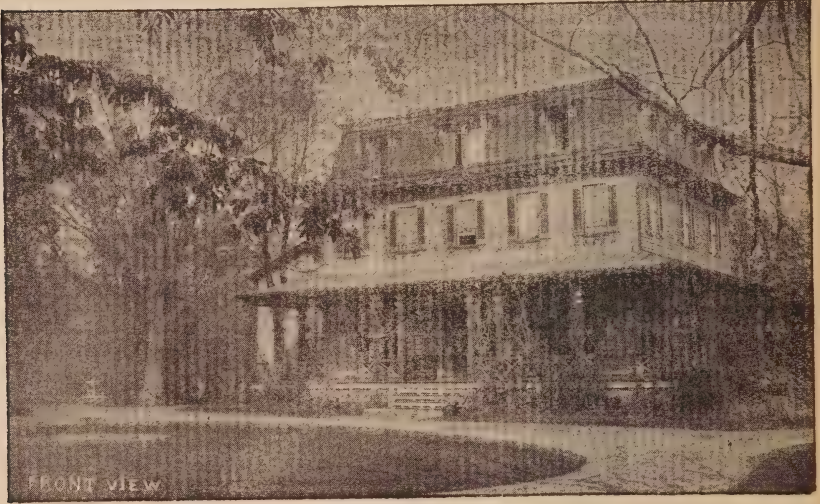
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Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Personal Notes.

DR. RUSSELL B. FREEMAN, '92, is practicing in Denver and is doing well.

DR. THOS. S. LOWE, '97, has gone to Manilla with the regular troops.

DR. H. DEWITTE SHANKLE, '89, has removed to Hendersonville, North Carolina.

DR. J. A. W. WEGEFARTH, '86, died of tuberculosis at El Paso, Texas, Dec. 8th, '98.

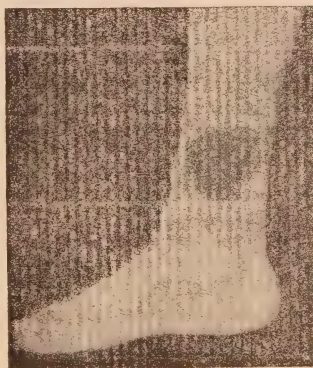
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Personal Notes.

DR. S. E. KOONCE, '96, is practicing at Pollocksville, N. C.

DR. D. S. FISHER, '84, is practicing and enjoying life at Reading, Kan.

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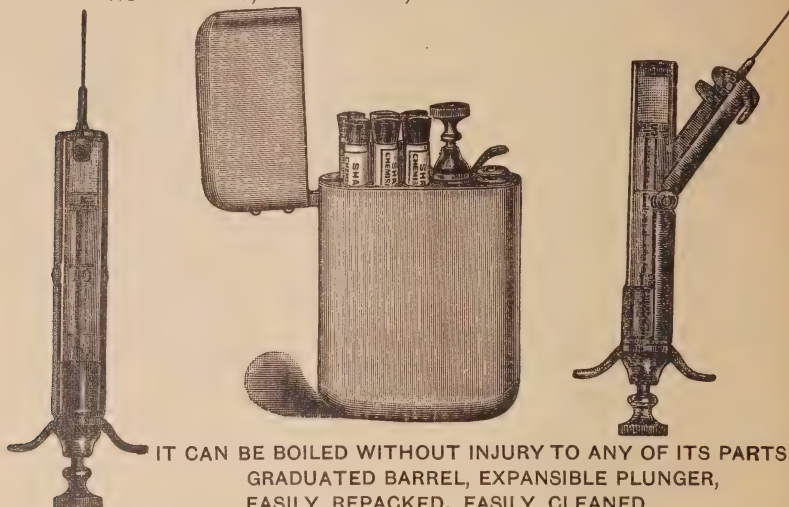
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BALTIMORE.

GEORGE H. ROHÉ, M. D.

Dr. Rohé was born in Baltimore county, Md., of German parents, and was educated in the schools of the county and of Baltimore. He took his medical degree at the University of Maryland in 1873. Soon after graduation he entered the U. S. Signal Service, and was stationed at Atlanta, Charleston, New Orleans and Boston. While in this latter city he began the study of dermatology under Dr. Wigglesworth. Upon leaving the Signal Service, Dr. Rohé came to Baltimore and for several years was assistant to the late Dr. Erich, formerly Professor of Gynæcology in the College of Physicians and Surgeons. Shortly after locating in Baltimore Dr. Rohé was appointed lecturer on Dermatology in the College of Physicians and Surgeons, and a little later assumed charge of the department of Hygiene. In 1887 he was elected Professor of Obstetrics, and in 1890 transferred to the chair of Therapeutics and mental diseases. He was appointed Health Commissioner of the city of Baltimore by Mayor Davidson, but before the completion of his term of service was elected Superintendent of the Maryland Hospital for the Insane to succeed the late Dr. Gundry.

After serving six years as superintendent of this institution he was elected Superintendent of the Second Hospital for the Insane at Sykesville, Md.

During the past year his health had not been good and his friends feared some serious cardiac trouble. While on a visit to New Orleans as a delegate to the National Prison Congress he was seized with an acute attack and died very suddenly in his room at the hotel.

In this brief sketch it is only possible to touch very superficially and without detail upon the salient points in the life of Dr. Rohé. As a public man he was widely known both in this and other countries. He was an authority on Hygiene and Public Medicine and his work on the former subject has been for years the text-book in many colleges. This book earned him recognition abroad, and he was corresponding member of a number of foreign scientific societies. His appointment as Health Commissioner of Baltimore was recognized at the time as the most fitting one that could be made, and he brought to the office not only zeal but a thorough knowledge of Public Medicine.

As a dermatologist he was widely known, and contributed largely to the literature of this branch of medicine. Perhaps, however, he will be longest remembered by his work as an alienist. After an experience of six years at Spring Grove Asylum, where he inaugurated many reforms and improvements, he began the great work of planning an asylum, or as he always insisted upon calling it, a hospital for mental diseases, upon the most advanced ideas. This institution, already celebrated as the most consistent example of the "open door" treatment of the insane in this country, will ever remain as a noble monument to Dr Rohé's genius and humanity.

As a professor, many of the alumni of this college will remember Dr. Rohé with love and admiration. He was a very interesting speaker, and always succeeded in infusing some of his own enthusiasm into his class. The members of the faculty came to regard him as a universal genius, for no matter what chair in the college he occupied, he filled it with marked ability. His versatility was marvelous. He was an authority on hygiene, a widely known dermatologist, a skilful obstetrician, and a distinguished alienist. Nor was this all, for during his service at Spring Grove he took a bold stand regarding the effect upon the mental condition of diseased pelvic organs, and

operated upon a large number of female patients. This work was widely noticed, and while it met with some opposition was regarded as an important step. It is not to be wondered at that a man such as Dr. Rohé was, should be popular, for he was an ideal companion. Affable, courteous, entertaining, witty, it was a never-ending delight to be associated with him. Long and lovingly will he be remembered by all the alumni of the College of Physicians and Surgeons.

SOME SMALL-POX STATISTICS.

BY DR. JOHN RUHRÄH, '94.
(*Quarantine Physician, Baltimore.*)

Actual hospital statistics are always of value even though one may not be able to draw any definite conclusions from them. The following are interesting from the fact that, as far as I have been able to ascertain, they have never been published. They show us several things, all old-established facts, the high mortality rate that small-pox may have in certain epidemics and in the unvaccinated, and that small-pox mortality is greatly lessened by previous vaccination. The figures given below illustrate the first point in a very striking manner. The second fact they show only relatively well and if I may be allowed I would refer the reader to the statistics given in the article on "Vaccinia" in Allbutt's System of Medicine.

These are the statistics of the Quarantine Hospital and are compiled from the Hospital records of Dr. James McHenry Howard, Dr. Sydney O. Heiskell and a few cases of my own.

Since the fall of 1881 there have been 1106 cases of small-pox cared for in the hospital of which there are fairly complete records as to mortality and vaccination. There were a few others in which these details were imperfect and they have been omitted.

These cases tabulated are as follows:

Vaccinated	441
Unvaccinated	645
Vaccinated unsuccessfully	20

Of the 441 cases which had been vaccinated:

Recovered	378
Died	63
Mortality rate	14.3%

Of the 645 unvaccinated cases:

Recovered	330
Died	315
Mortality rate	48.8%

In the 20 cases where the vaccination had been unsuccessful:

Recovered	14
Died	6
Mortality rate	30%

All cases without reference to vaccination we find:

Recovered	722
Died	384
Mortality rate	34.7%

The most of these cases were in the hospital during the epidemic of 1881-82-83. The mortality rate of the cases taken all together is quite high. Of the unvaccinated almost every other case died, while on the other hand in the vaccinated we find only a mortality rate of 14.3%. This is high but taking into consideration the otherwise unusually high mortality it conferred a great protection.

Where the cases had been vaccinated and it did not take the mortality stands about midway between the vaccinated and the unvaccinated. There was some degree of immunity but not a very high degree. It is fair to state that in the cases counted as vaccinated most of them had been vaccinated but once and often that was marked as having been done years ago, showing that the immunity had worn off and emphasizing the necessity for revaccination.

In 105 cases the variety of the disease was also stated. These were as follows:

Vaccinated 55.—Recovered 49: discrete 43, confluent 6; died 6: discrete 1, confluent 5.

Unvaccinated 50.—Recovered 27: discrete 15, confluent 12; died 23: discrete 0, confluent 21, hemorrhagic 2.

These latter figures are more striking. In the vaccinated the percentage of recoveries was greater and most of the cases discrete. All but one of the fatal cases were confluent, and in the discrete case that died the cause of death was a secondary pneumonia. In the unvaccinated most of the cases were confluent with the consequent high mortality.

As might readily be supposed the mortality was highest when the hospital was the most crowded.

There were four cases of hemorrhagic small-pox, all in adults. One had been vaccinated when a child, the other three were unvaccinated. This varies with the average observation that the hemorrhagic form is most frequent in those who have been vaccinated but once and not so frequent in the unvaccinated cases.

Almost all of the cases were in adults. Cases in vaccinated children under ten years of age were exceptional. This is a notable fact when one considers in that in the pre-vaccination days small-pox was a disease of childhood as much as scarlet fever or measles of to-day.

A CASE OF GUNSHOT WOUND OF ABDOMEN WITH MULTIPLE INTESTINAL PERFORATIONS.

(From the Clinic of Dr. J. W. Chambers).

BY DR. H. WESTPHAL, '98.

R. L., colored, æt. 15 years, accidentally shot by playmate in abdomen with a 32-caliber revolver, weapon being held at a distance of about 25-30 cm.

On admission to hospital, one hour after accident, was considerably shocked, pulse 120, small. Temperature 98.

Morphine sulphate, 0.012 } were given
Strychnine sulphate, 0.002 } hypodermically.

Upon examination presented gunshot wound 2.5 cm. internal and 1.5 cm. above anterior superior spine of ilium (right), from which (the wound) 12 cm. of omentum were protruding. External hemor-

rhage had been inconsiderable. The patient was immediately prepared for a laparotomy.

Operation, 1 hour after admission: Dr. Chambers, chloroform narcosis. Time 1 hour 17 minutes.

After clamping a pair of artery forceps to the protruding strip of omentum, the abdomen was opened mesially from 2.5 cm. below umbilicus to 2.5 cm. above crest of symphysis pubis.

A good deal of blood-stained serum oozed from wound.

The intestines were then protruded and the following traumata found:

Small intestines, perforations, complete.....	4
Small intestines, perforations, partial.....	2
Small mesentery, perforations, complete.....	2
Cæcum, perforations, complete.....	2
Appendix vermiformis, perforations, complete.....	1
Ascending colon, perforations, complete.....	1
Ascending colon, perforations, partial.....	1
Meso-colon, perforations, complete.....	1
Meso-rectum, perforations, complete.....	1
Rectum, perforations, complete.....	1
<hr/>	
Traumata.....	16

The wounds in the cæcum were near ileo-cæcal valve.

Near wound of colon was a blood suggillation size of silver dollar.

As the perforations were encountered, their edges were trimmed and united by interrupted and continuous Lambert or Halsted's quilted sutures, No. I silk and No. X cambric needles being used.

The trimming of the wound edges caused no appreciable hemorrhage except in one case, and then the bleeding vessel was readily secured by "Umstechung."

The partial perforations, which penetrated to the mucosa or muscularis mucosæ were drawn together by purse-string sutures.

The appendix was entirely severed, the two pieces being held together, on one side by its mesentery and on the other by a thin strip of serosa.

After ligating the mesentery and its artery, the serosa was dissected back towards the cæcum, and after ligating and cutting away appendix, was untied over the stump. A piece of cloth, corresponding to hole in boy's trousers, was found near appendix.

No attempt was made to locate the projectile. During the operation the abdominal cavity was occasionally flushed with hot 0.6 per cent. sod. chlorid solution, which brought away a moderate amount of blood-clots and fæcal matter.

As the intestines were protruded they were protected by towels wrung out of the same solution.

After a final flushing the protruding strip of omentum was ligated, cut away, and the stump allowed to slip into the abdomen.

On attempting to put an iodoform gauze drain into gunshot wound, it was found that the shifting abdominal muscles had entirely occluded its canal; opening was made by knife.

The operative wound was next closed by seven interrupted sutures, including all structures from peritoneum to skin.

One-half hour after operation, temperature 96.2° , pulse 125 very small.

Hot bottles.	{ Strychnine,	0.002	} hypod.
	{ Morphine,	0.012	

Opium, 0.06 every 4 hours.

Next morning, November 15, 9 A. M.: Slept very little during night, good deal of pain. Comparatively easy now. Thirst intense. Cracked ice, milk, bouillon.

At night: Tinct. opii camph., 10.0

Chloral, 1.0

November 16. Slept poorly, no stool. Distressing tympanitis, relieved by nicking bandages.

November 17. Slept all night, free from pain.

November 18. Painless, easy stool, no blood. Temperature 99° . Pulse 80. Temperature at no time rose above 100° . Opium discontinued. Soft diet.

November 19. *First Dressing.* Operative wound clean. Gunshot wound bathed in stinking pus. (*Bacillus coli communis*).

Drain renewed. Wall of cotton saturated with iodoform collodion thrown between the two wounds, separate dressings.

November 23. *Second Dressing.* Union of operative wound good. Slight superficial infection. Copious iodoform dressing. Tendency to constipation which had existed for some days, overcome by small and repeated doses of ol. ricini. Full diet.

November 29. Operative wound clean. Sutures removed. Gunshot wound almost closed, drain discontinued.

November 5. Patient feels perfectly well, up and about. All that remains of the gunshot wound is a small cutaneous defect.

November 10. Wound sluggish, curetted.

November 20. Cicatrization complete.

CEPHALIC VERSION AFTER THE BEGINNING OF LABOR.

BY DR. WILLIAM S. GARDNER, '85.

Cephalic version, mentioned by Hippocrates, practiced for centuries by the Arabians, finally fell into disuse, and was only revived in Europe about the beginning of the present century. At the present time it is spoken of as the exceptional operation, for which exceptionally favorable conditions must be present. Ordinarily it is stated that cephalic version may be performed when the child is in a transverse position, if the waters have not escaped and the uterine contractions are not too strong. The difficulties of the operation have been exaggerated, and its advantages, especially those to the child, have been belittled.

Indications.—When the pelvis is sufficiently large to allow the passage of a living child, cephalic version is indicated in all presentations where neither pole is presented to the superior strait, and in many, if not all, breech presentations. The limits of the possibility of performing it are slightly less than that of podalic version. The practicability and even the possibility of doing either cephalic or podalic version in cases where the waters have long escaped, and the uterus

firmly retracted upon a large child, wedged firmly in the pelvis, is always a matter for grave consideration. But the single fact that the waters have escaped does not necessarily contraindicate cephalic version. Two cases have been recently reported, in one of which the waters had escaped three hours before the operation, and, in the other, fifteen hours had elapsed before turning was attempted. In one of my own cases the waters had escaped several hours before I saw the patient. Yet, in not one of the cases was any special difficulty encountered. Cephalic version is not recommended in placenta prævia because the legs of the child can be made to plug up more effectually the partially dilated cervix. In cases where repeated breech presentations in the same patient have resulted in the death of the infants, cephalic version labor is positively indicated.

The advantages of cephalic version over podalic version operate in favor of both mother and child. To the mother the shock of the operation is not so great, especially when the version is done, as it usually is, by external manipulation. The increased danger of laceration of the cervix in podalic version is avoided. This danger is greater after podalic version than in ordinary breech presentations, for the reason that the head is often dragged rapidly through an only partially dilated os. In cephalic version the danger of laceration of the perineum by the rapid extraction of the after-coming head is avoided.

The foetal mortality due to podalic version is difficult to estimate, because the operation is usually done under or on account of such circumstances as would in themselves endanger the life of the child, if its delivery be attempted by any method through the natural channels; consequently it is plainly unfair to charge to an operation results that may be entirely independent of it. But it is certainly giving the operation liberal treatment to say that as a result of the position obtained by the operation, the foetal mortality is at least as great as in breech presentations.

The foetal mortality in breech presentations is so variously estimated from hospital reports that we can estimate only approximately what the mortality is in general practice. Dubois estimated that one child

in eleven, or about nine per cent., of children presenting by the breech are still-born. This is, presumably, under the very best management. No reference is made to the frequency of lacerations of the cervix or the perineum, which were undoubtedly very common. Churchill estimates the foetal mortality at one in $3\frac{1}{5}$, or 30 per cent. Galabin says that at Guy's Hospital, where the cases are attended by students, the foetal mortality in breech presentations is one in 2.7, or 37 per cent.; and in foot or knee presentations one in 2.2, or 45 per cent. The estimate of Dubois shows the percentage of mortality under the most skilful management; that of Guy's Hospital under the management of students, presumably the least skilful; and Churchill's estimate is, in all probability, very close to the results obtained by the average good practitioner.

Bearing in mind the statement of Tyler Smith that "Spontaneous pelvic presentations are less dangerous, both to the mother and child, than artificial pelvic presentations procured by the operation of version," and also the fact that the foetal mortality in vertex presentations is not more than two or three per cent., the above estimates are certainly arguments in favor of cephalic version that cannot be successfully disputed. It must not be understood that I would abandon or decry the valuable operation of podalic version; but it undoubtedly should be limited to that relatively small number of cases to which cephalic version is not applicable.

Before attempting cephalic version, it is of course necessary to make out accurately the position of the child. In some instances this can be done by vaginal examination, but much more frequently it must be done by palpation. Even in primipara it is not often that the abdominal walls are so tense as to interfere with the external examination. The patient should be flat on her back with the knees flexed. Standing at the side of the patient, with his face toward her feet, the examiner places his warm hands at first gently on the abdominal wall, and then pressing the fingers of each hand deeply into the corresponding iliac region, he presses the finger tips of each hand toward the other. In this way the lowest segment of the uterus and its contents are grasped between the two hands. If the head is down

it can be recognized easily by its shape, resistance, and by what is of very great importance, the crease corresponding to the neck. If the head is not found in this segment of the uterus, we then know that the child is in one of the more unusual positions. Grasping between the fingers in the same way successively the lateral halves and the fundus of the uterus, it is usually quite easy to make out not only the position of the head and back of the child, but very often the limbs can be found.

Auscultation, though much inferior to palpation, is of some service in locating the position of the child.

Generally speaking, in head presentations, the foetal heart is heard with the greatest distinction below a line which crosses the uterus transversely at a point half way between the symphysis and the fundus of the uterus. This line usually runs about one inch below the umbilicus. The objection to taking the umbilicus as a guide is that it is not a fixed point and its relation to the uterus varies greatly in different women. In pelvic presentations the heart sounds are heard usually above this line. In no presentation is the relation of the foetal heart sound to a given point on the abdominal wall definite.

When a malpresentation has been made out there are four methods that have been used to correct it. One of the older methods is by posture. This consists simply in making the patient lie on that side to which it is wished that the breech should gravitate, and waiting. While this method has succeeded, it is too uncertain to be of very great practical value. The principal details of the other methods will be given in the relation of the cases. Before beginning the operation by any method, it is necessary that the rectum and bladder be emptied.

CASE I. C., colored, multipara, was brought to bed with twins. The first child presented by the vertex and was born without assistance. The second child presented by the left shoulder, the head being in the right iliac region. The second bag of waters was unruptured. An attempt was made to rectify the position by external manipulation without an anæsthetic, but on account of the uterine contractions it failed. Chloroform was then given with the intention

of doing a podalic version; but upon introducing my hand I found the child so movable that I grasped the head, brought it to a L. O. A. position and retained it there until the pains returned. The labor was then allowed to proceed without interference, and in a few minutes a living child was born.

The objections to this method of turning are that it is rarely available, and necessitates the introduction of the whole hand into the uterus, which is one of the greatest objections to podalic version as it is usually performed. What was gained was the avoidance of the dangers of the after-coming head. In this particular case very little danger was to be apprehended from the after-coming head, but what there was was forestalled by having the head come first.

CASE II. A. B., white, primipara. Labor began about 1 P. M., September 7, 1890, at which time she informed the nurse that her "sickness had come on." By digital examination the attending physician found clots in the vagina and a partially dilated os, through which no part of the child could be felt. That evening the hæmorrhage was controlled by tamponing the vagina with cotton. The case came under my charge September 8. Upon removing the tampon, the cervix was found to be only slightly dilated and filled with blood-clots. No part of the child could be reached through the vagina. By external examination the head was found in the right iliac region and breech opposite. At 12.30 P. M., under chloroform, by external manipulation the breech was pushed upward and the head forced down until it occupied the lower segment of the uterus and was ready to engage in the superior strait. The tampon was not replaced and there was no further hæmorrhage. The pains were not strong and the os dilated slowly. At 10.47 P. M., the os having dilated about one-half, and the pains being very weak, the membranes were ruptured. After this the pains became stronger. During the night chloroform to the obstetrical degree was given. At 6 A. M., the os was fully dilated, but the head, in the R. O. P. position, did not descend. At this time, under chloroform, forceps were applied, and at 6.35 the head, unrotated, was delivered. The perineum was not torn. Both mother and child did well.

CASE III. No. 1780, colored, aged 16, primipara. Labor began about noon, April 7, 1891. I saw her for the first time the following day about 1 P. M. Upon digital examination I found that the waters had escaped, the cervix partially dilated, the head of the child in the right iliac region, and the right arm of the child in the vagina. As I withdrew the examining finger the child's hand came through the vulva.

Chloroform was at once given, the arm put back into the uterus, the shoulder pushed up from the superior strait by the fingers of the right hand, while the head was fixed with the left hand. As soon as the arm was safely in the uterus the right hand was applied to the breech, and by pushing it up, at the same time the left hand pushed the head down, the presentation was quickly converted into a vertex. The chloroform was stopped and the living child was born, without further interference, in less than an hour.

Undoubtedly the best method of doing cephalic version is by external manipulation. Mundé puts it in this way: "The paramount advantage of version by external manipulation is the avoidance of the always more or less hazardous passage of the whole hand into the uterus." The operation is not difficult, and any one who is at all familiar with palpation ought to have no difficulty in performing it.

Next to the external manipulation in ease and safety of performance is the combined method, while the method of passing the hand into the uterus and grasping the head is less valuable both on account of the infrequency of the conditions favoring its performance and on account of the shock to the mother.

Whether a cephalic version shall be done should not be looked upon as a question of the convenience of the physician, but as a question involving the safety of the mother and the life of the child. By these facts and cases I have endeavored to show that in cephalic version we have a neglected operation which presents no special difficulties in performance, and which if carefully cultivated will undoubtedly reduce our foetal mortality.

MEDDLESOME INSTRUMENTATION IN URETHRAL DISEASES.

BY DR. W. L. CHAMPION, '91.

The ugly train of symptoms that follow in the wake of bad urethral surgery, and the results obtained from such instrumentation is frequently a monument as lasting to the surgeon as a fracture improperly treated. It seems the impression is prevalent in the minds of some, that the urethra has no function at all, but was made for the surgeon's use to demonstrate his skill in the use of instruments.

Considering the teachings of to-day and our knowledge of the importance of cleanliness in surgery, it is a puzzle to know why physicians continue to thrust dirty instruments, made sleek with rancid grease, into the urethra and bladder, producing untoward results and not knowing the source of infection. If the instruments are clean, it frequently happens that they are passed into the bladder, carrying purulent material retained within the urethra. While a diseased urethra is as a rule an unclean canal, it frequently happens that the deep urethra and bladder are in a healthy state, so there is no common sense in "adding fuel to the fire" by using unclean instruments or forcing poisonous material into uninfected areas.

The close observer rarely overlooks the origin of urethral fever, swelled testicle, cystitis, prostatitis, damaged kidneys and many serious conditions directly due to the meddlesome use of instruments. Not to be a meddler in the treatment of genito-urinary diseases, it is essential to be familiar with the use of instruments; to know when to use them, and what kind of instruments to use.

The use of small steel instruments, below 18 or 20 French cannot be too strongly condemned. With our knowledge of the anatomy of the urethra, and of the dangers of passing small steel instruments, false passages should be a thing of the past. The soft bougies, though not as durable as the steel sounds, accomplish the same results, and should always be used when a small instrument is called for; and even the larger ones are just as serviceable and produce less pain on introduction.

The routine practice of passing sounds *into the bladder*, in treating strictures in the penile portion of the urethra, is not only useless but bad surgery. There is always a liability of infecting the bladder, and producing irritation of the prostatic urethra. The short, straight sound passed through the stricture accomplishes the same result as the curved instrument, and the danger of producing complications is lessened.

An important point that should never be overlooked is the necessity of having instruments perfectly clean that are to be introduced into the bladders of old men with enlarged prostate; and this point should always be impressed upon the patient when he is given a catheter to use.

The carelessness with which instruments are thrust into the urethra frequently results in permanent injury to the tissues. "It is a very easy thing to force a catheter or sound through the urethral walls, or to produce sufficient injury by bruising and laceration to result in cicatricial deposit and consequent stricture." This is especially true when the canal is highly inflamed; and probably many of you have had cases of cystitis, and later organic stricture to treat due to meddling surgery of this kind.

The custom of many physicians of using the steel sound for exploring the urethra, to determine whether stricture is present or not, should be abandoned. The sound is practically worthless as an instrument to arrive at any knowledge as to the condition of the urethra. Patients frequently present themselves for treatment who have been examined with sounds and told there were no strictures present, when a proper examination would reveal a badly strictured canal. A stricture that can be detected by a 25 bulbous bougie will frequently admit a thirty sound, and for this reason errors in diagnosis are made.

To meet with success in the treatment of urethral diseases it is necessary to make a careful examination. Neglect in this particular is why many failures are recorded. Patients with contracted meatus that will admit only a 26 or 28 bulbous bougie (urethrometer not being used) are told that they have no stricture, when it is impossible to determine whether the urethra is free of strictures until a bulbous bougie as large as the urethra is introduced.

The mistaken idea that every apparently gleet discharge from the urethra is an indication for the use of the sound is clearly shown in the discharge due to prostatic congestion, discharge from gonorrhœal inflammation of the seminal vesicles, the discharge of long-standing after epididymitis, the discharge we frequently see from syphilitic mucous patches within the urethra, and other conditions that respond to proper treatment.

When a patient presents himself for treatment, if he has a highly sensitive urethra or discharge from the canal, first treat the urethra by irrigation until the sensitive condition has disappeared and discharge has been controlled, before making an examination or commencing treatment with instruments.

In treating stricture of the urethra by dilatation how often should we pass an instrument? This question has been written upon, argued and discussed at length, and there seems to be a wide variance of opinion as to the length of time that should elapse between the sittings. In the use of sounds for the treatment of stricture there can be no fixed law in regard to the intervals to be allowed between the sittings. Each case must be watched separately, and the results of the introduction of the instrument noted, so as to determine when to use the instrument again. My opinion is that the majority of men not studying the effects produced by an instrument passed through an organic stricture, influenced by the patient's desire for a rapid cure, are prone to pass instruments too often, thereby setting up an acute inflammatory condition and prolonging the treatment.

My experience in the treatment of urethral strictures coincides with that of Dr. Keyes, of New York. Probably most of you know his views on this question, but I will quote him at length so as to be plainly understood. He says: "Suppose a stricture which sensibly diminishes the size of the stream of urine, and is attended by gleet. Through this stricture a conical instrument is introduced, which is arrested for a moment, but gradually passes, stretching the stricture, and is distinctly 'grasped' as it is being withdrawn. What follows such an operation? At the next act of urination the stream is larger, and continues so during twenty-four hours. At the end of that time

the stream is nearly as small as it was before the sound was used; the gleet is the same, or possibly increased. Now, for twenty-four to forty-eight hours the stream steadily becomes smaller, while the discharge grows more abundant and creamy. During the third or fourth day, improvement commences; the stream again grows larger, the discharge becomes thinner and less copious, and this improvement often continues through the fifth and sixth or even seventh days, or longer, after which the volume of the stream commences to diminish and the discharge to become thicker. In such a case, if the same conical instrument first used had been reintroduced at the end of twenty-four hours, it would have passed the stricture with about the same facility as on the day before; if after forty-eight hours, it would enter with more difficulty; if at the end of seventy-two hours, it would again enter as easily as on the first day; if reintroduction were first attempted on the fourth day, the sound would pass more easily than at first; if on the fifth, with more ease still, and it would not probably be so tightly 'grasped' on withdrawal; while in some cases the greatest ease of reintroduction is attained on the sixth, seventh, eighth day, or even later. This varies in different cases; but it may be stated, as a rule, *that it is bad surgery, in treating stricture by dilatation, to reintroduce an instrument—unless it be filiform—before the lapse of at least seventy-two hours, and that more rapid progress will be made with the case by waiting till after ninety-six hours—often even until the sixth, seventh or eighth day.*"

If any one doubts the truthfulness of the above statement, all that is necessary to be convinced to the contrary is to watch the effect of an instrument under the same circumstances.

The cure of a stricture by dilatation is brought about by "absorption" of cicatricial tissue, so if the stricture is not stretched up to the full size of the urethra, the cure is not perfected, and recontraction will in all probability take place. This holds true in regard to strictures that have been cut; and a large percentage of the urethrotomies that are not successful are due to neglected after treatment. If a stricture can be cured by dilatation, the surgeon is not justifiable in subjecting the patient to a cutting operation, that might possibly

prove fatal. Strictures of recent formation, situated in the pendulous portion of the urethra, can usually be cured by dilatation, and those in the deep urethra respond readily to this method.

Now, in regard to internal urethrotomy in the deep urethra, I know there are men who do this operation with but few accidents, but the best practice is to positively refuse to interfere unless the patient will submit to the external operation. The custom of doing internal urethrotomy in the office, and allowing the patient to go home in a hack or on a car cannot be too strongly condemned. It is an operation that is fraught with danger, so we should guard against any mishap, and give the patient the best treatment possible. The operation should be done at home, and the patient kept in bed for at least five days, and it would be safer still to require a week's rest.

The mere cutting of a stricture will never cure it; it is absolutely necessary to keep the urethra dilated up to its full size until perfect healing takes place, and all cicatricial tissue has disappeared as far as the sound will accomplish.

Before a stricture is cut the size of the urethra should be determined, and the stricture cut to this size. Then introduce a bulbous bougie and see if the slightest band of cicatricial tissue is left; if so reintroduce the urethrotome and cut all remaining bands. If the word meddling applies to any operator, it is the one who cuts a stricture to number 32 when the caliber of the urethra is 34, and never introduces a sound larger than the size the stricture was cut to. An operation of this kind cannot give relief; for in the future there will probably be a recontraction of the stricture. The same kind of operative work is done in cutting the meatus: it is either not cut to the full size of the urethra, or neglected and not kept dilated until healing takes place.

It is not my intention to appear dogmatic in regard to these apparently simple operations, but I so frequently see strictures that were improperly treated, and meatus that have to be incised a second time, that I cannot refrain from emphasizing these important points.

In my opinion, after internal urethrotomy instruments are frequently passed too often; every fourth, fifth, or sixth day will give

just as good results, and less pain to the patient, as when passed on the second and third. The nearer the stricture is to the meatus the shorter should be the intervals between the sittings.

It is bad practice to try and force an instrument through a stricture; it always results in damage to the urethra. If a stricture is of such small caliber that it seems impossible to pass an instrument at all, I feel sure that in many cases, if a stream of water is thrown against the stricture with an irrigator for a few minutes, that an instrument can be passed into the bladder. Under similar circumstances, if a two or four per cent. solution of cocaine is deposited at the stricture, it will produce contraction of the engorged vessels and tissues to such a degree that a filiform, or even larger instrument, can be passed.

The deep injection syringe, an instrument that is in general use, and one no doubt that has served a good purpose, is inferior to the endoscope. With the syringe it is a matter of guesswork whether the solution is deposited at the seat of inflammation; but with the endoscope we can make a careful examination of the entire urethra, and limit the application to the diseased surface.

Every discharge from the urethra of long standing is not due to a stricture that requires cutting or dilatation. In many cases the discharge is due to a chronic inflammation that produces a slight thickening of the urethra, and is diagnosed and occasionally operated upon as a stricture of large caliber. Strictures of this kind, if they can be called strictures, are the ones that give such quick and happy results from direct applications through the endoscope.

The granular condition that remains after a stricture has been dilated or cut to its full size, will respond more promptly to local applications through the endoscope than other means. While the sound and deep injection syringe was originally and is yet used for the relief of these conditions, it is impossible to know the condition the urethra is left in when the patient is dismissed.

I frequently have patients who, having had a gleety discharge from the urethra for years, and having been treated with sounds for stricture until completely disgusted with instruments, make a perma-

ment cure of the granular condition by a dozen or fifteen applications through the endoscope. The endoscope I use, and think one of the best, is Otis's instrument, with electric attachment, and Klotz tubes. The ordinary urethral tubes, with a head mirror to reflect the light, will not give satisfaction.

It is necessary to the surgeon's success and the patient's welfare to ascertain the condition of the patient's kidneys before doing an operation upon the urethra. I remember very well a case where an external urethrotomy was absolutely necessary to relieve a tight stricture of the deep urethra, that had caused a rupture, and the patient died from the suppression of urine fifteen days after the operation, due to structural derangement of the kidney that was present before the operation. In urethral surgery preparatory treatment is very necessary. The bowels and kidneys should be in good working order, the urine should be rendered aseptic as far as possible, the parts to be operated upon should be thoroughly cleansed, and a dose of quinine before and after the operation is advisable. Taking these precautions will, I feel satisfied, reduce the mortality in surgical operations upon the urethra.

In closing, I would like to emphasize the importance of irrigation before surgical operations upon the urethral canal, whether it be only the passage of a sound or an internal urethrotomy. If this is done there will be fewer cases of urethral fever and less irritation and inflammation after using instruments. Within the past twelve months I have used "hydrostatic irrigation" in the treatment of inflammatory conditions of the urethra and bladder, and it is far superior to any other method. The container, which holds a prescribed quantity of the solution to be used, at a temperature of 110° F., is placed eight or nine feet from the floor. A glass nozzle is used to throw the fluid into the urethra and bladder. The anterior urethra is first thoroughly washed out, and then the nozzle is pressed firmly against the meatus, and the patient told to breathe deeply or try to urinate, and the fluid flows back into the bladder. When the bladder is full the patient is allowed to pass it out, and the bladder is refilled. The value of this method is that the urethra is distended to its full capacity, which forces the pus and germs from the glands and follicles of the canal.

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LATENT CANCER OF THE STOMACH.*

BY DR. JULIUS FRIEDENWALD, '90, AND DR. A. S. HOTALING, '94.

The diagnosis of carcinoma of the stomach is at times very difficult. This difficulty is apparent in the one hundred and thirteen cases of carcinoma of the stomach collected by Guinard,¹ in which the diagnosis had been made in only thirty-four cases. These cases, however, were collected from reports in the *Bulletin de la Société Anatomique de Paris*, most of them being remarkable for some anatomical or clinical peculiarity in diagnosis. There are many cases of carcinoma of the stomach in which the cardinal symptoms are absent and yet the diagnosis can be made from other symptoms; there are other cases, however, in which not only are the cardinal symptoms entirely absent, but all other symptoms, if present at all, are so insignificant that they do not lead one even to suspect a carcinoma; such cases are known as latent cancer of the stomach.

There are two varieties of latent cancer: First, those cases in which the gastric symptoms are absent or so insignificant that they are masked by other general symptoms. Thus the carcinoma may be masked by some intercurrent disease, or secondary metastases from a primary gastric carcinoma may hide the primary disease. Secondly, those cases in which there are no symptoms whatever, general or local.

Of the first variety a large number of cases have been reported; of the second the cases are few. The pathological conditions leading to latency are that the growth be located on the anterior or the posterior wall of the stomach in such a position as to involve neither the cardiac nor the pyloric orifice, and that the surface of the tumor does not become ulcerated. When either of these orifices is involved, symptoms of obstruction are at once manifested; if there is marked ulceration, toxic symptoms are produced.

Latent cancers of the stomach have been observed by Cruveilhier and Barth, and cases have been reported from the clinics of Trousseau, Andral, and Guéneau de Mussy. Chesnel² has reported six

* Read at the Annual Meeting of the Medical and Chirurgical Faculty of Maryland, April 27, 1898.

cases; three of these were masked by pregnancy; in another case, in a man who had died suddenly from apoplexy, a cancer of the stomach was discovered at the autopsy; in still another case presenting the clinical symptoms of Bright's disease a similar discovery was made.

Raymond³ reported a case in which there were no gastric symptoms whatever; there were a sudden and very high elevation of temperature and a general and apparently eczematous eruption. The true condition was revealed at the autopsy. In another case, that of a man aged fifty-six years, the only symptoms were marked cachexia and general œdema. The autopsy revealed a large carcinoma of the walls of the stomach, not involving the orifices.

E. Brissaud⁴ relates a case of a man, aged fifty-seven years, who entered the hospital suffering with intense anorexia; there was much emaciation but neither vomiting nor any digestive disturbance. He continued in this condition for twenty-two days, when fever suddenly came on with intense pain in the chest. A purulent pleurisy was discovered; soon the joints became infected and there were other manifestations of pyæmia. The patient died and a large cancer of the lesser curvature of the stomach was discovered. Many of the joints were found filled with pus and the left pleura contained a large quantity of pus.

Brodeur⁵ reports a case, that of a man, aged eighty-seven years, with a good antecedent history, who complained of loss of appetite, slight nausea, though not vomiting, and alternating constipation and diarrhœa. Œdema came on and he died. At the autopsy a large encephaloid carcinoma of the stomach was found not involving the orifices, but the greater curvature of the stomach was entirely destroyed, and its wall was replaced by the spleen; the left kidney and the liver were also involved. In spite of the extensive ulceration there had never been vomiting or hæmatemesis or pain. This case is remarkable as showing how far the destruction of the stomach may go without producing any marked symptoms.

An interesting case is reported by Goldscheider.⁶ A woman, aged sixty-one years, presented symptoms of a compression myelitis, the cause of which could not be determined. At the autopsy a carcinoma of the spinal column was discovered, which was secondary to a carcinoma of the lesser curvature of the stomach. In this case there were no symptoms whatever of gastric disturbance.

Hameln⁷ reports a number of cases. In one of the diagnosis of senile marasmus and arterio-sclerosis was made; in another pulmonary tuberculosis; in still another pernicious anæmia. In all of the cases

carcinoma of the lesser curvature was found. In two febrile cases the diagnosis had been malaria and abscess of the liver.

Aron⁸ demonstrated before the Medical Association of Berlin a specimen of latent cancer of the stomach. The patient, a man, aged seventy-eight years, had become emaciated and had œdema of the face and extremities, ascites, and fluid in the pleural cavities. Nothing could be determined by examination except the existence of an enlarged liver. At the post-mortem examination a large ulcerated carcinoma was found involving the greater curvature of the stomach.

Leichtenstern⁹ reports three cases. In the first there was an acute compression of the spinal cord with paraplegia due to a secondary lesion in the stomach. This had not produced any gastric disturbance. In the second case the diagnosis of acute miliary tuberculosis had been made. There were ascites, abdominal pains, and symptoms of chronic peritonitis. At the autopsy miliary carcinosis of the peritoneum was discovered secondary to a primary scirrhus carcinoma on the posterior wall and greater curvature of the stomach. The third case was one of chronic nephritis. There was hypertrophy but there were no gastric symptoms except occasional vomiting. The trouble was believed to be uræmic. The patient died of uræmia, and at the autopsy, besides the cardiac and renal lesions, a carcinoma on the lesser curvature of the stomach was discovered.

Similar cases have been reported by Loiseaux,¹⁰ Lafourcade,¹¹ Bosowski,¹² Gombault,¹³ Lefebvre,¹⁴ and Bouveret.¹⁵

The case which we report is of considerable interest. A. W—, colored, aged seventy years, entered Bay View Asylum on March 15, 1897. He was in good general health, with an amount of arteriosclerosis usual at that age. He at no time complained of feeling ill. On July 3d he died suddenly. The autopsy was held July 4th. The following is taken from the post-mortem report: Height, five feet five inches. No rigor mortis; much emaciation.

Heart. The mitral orifice admitted two and the tricuspid orifice three fingers; weight, two hundred and twenty grams. The anterior segment of the tricuspid valve was slightly thickened along its edge; the pulmonary segment was normal. There were patches of arteriosclerosis along the base of the aortic segments of the mitral valve and a small calcareous deposit along the posterior segment of the mitral valve at the base. The aortic segments were slightly thickened. The coronary arteries were marked by sclerosis with a large deposit of calcareous material, causing them to be stiff and brittle. The right ventricle was four millimeters in thickness; left ventricle, eleven milli-

meters; aortic orifice, nine centimeters. There was marked evidence of fibrous myocarditis.

Lungs. The left lung was free from adhesions; weight, four hundred and fifty grams. Hypostatic congestion was noted in the lower lobes. The right lung weighed five hundred and twenty grams, and was congested in the lower lobe.

Kidneys. The left weighed one hundred and forty grams; its capsule was somewhat adherent and it was pale in appearance. The pyramids were well preserved and normal in appearance, the medullary rays could be made out, and the glomeruli were readily visible. There was evidence of parenchymatous changes. The cortex was four millimeters in thickness. The right kidney weighed one hundred grams; its capsule was rather adherent; it was the same in appearance as the left kidney.

The liver weighed twelve hundred grams and was normal in appearance. The left lobe was adherent to the lesser curvature of the stomach.

The most interesting condition was found in the stomach. In the region of the lesser curvature, occupying both anterior and posterior walls, was a tumor mass sixteen by eleven centimeters, varying from one-half centimeter in thickness and projecting into the cavity of the stomach. The tumor was slightly pedunculated, the free edge of the tumor in places overhanging the attached base as much as two centimeters. Nodular projections were scattered over the surface. There were two or three ulcerated areas on the surface of the tumor, from one to two centimeters in diameter. The mass extended into the cardiac orifice but did not involve it. Scattered over the mucosa of the stomach were a dozen small nodules, one centimeter in diameter; some were pedunculated. The mass had extended through the muscular layer of the stomach.

No evidence of metastases could be found in the neighboring lymphatics. On section a considerable mass of fibrous tissue was visible; on pressure a white pulpy material was expressed in the vicinity of the ulcer. The stomach was normal in size and position.

Microscopically the tumor was found to be an adeno-carcinoma. The cylindrical cells lined the ducts very regularly in some places; in others the arrangement was very irregular and many of the cells had undergone necrosis. The ducts were separated by connective tissue, which showed considerable small-cell infiltration.

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ANNOUNCEMENTS.

Announcement of Graduates, Friday, April 14th.
Competitive Examination for Prizes, Saturday, April 15th.
Alumni Meeting and Banquet, Monday, April 17th, 8 P. M.
Commencement, Ford's Opera House, Tuesday, April 18th, 12 M.
Rev. Ernest C. Smith, orator.

DYSMENORRHŒA.

In reviewing the records of 300 cases of dysmenorrhœa in which the pelvic organs were examined 273 were found to have some gross pathological lesion. In only 27 was no marked lesion found. The inference is clear. The old classification of obstructive, congestion, ovarian, neuralgic dysmenorrhœa is useless. Examine the patient and treat the lesion found. If no lesion is found examine her again or get one of your friends to assist you. There are more than nine chances in ten that a lesion is present. To treat a patient by the administration of drugs without first making a diagnosis is foolish. The pain at the menstrual period is only a symptom of some disease. Make the diagnosis first then you will be able to treat the condition intelligently.

The JOURNAL has completed its first year, and with this number begins its second year's effort to carry the feeling of good fellowship among the alumni. Let every one contribute his mite of information during the year. If you know anything about yourself or about any one else write to the JOURNAL and it will go directly to over two thousand alumni who are eager to get news from all of the boys.

The alumni will please bear in mind that the JOURNAL will be glad to receive articles from them at any time. It is particularly desired that a reprint of all papers published elsewhere be sent in.

As soon as the present session is over, work will be begun at once on the New College Building. The present lecture halls will be torn down and will be replaced by a fine five-story structure containing four lecture halls, and other rooms to be used as clinical rooms, laboratories and demonstration rooms. The increased space gained by rebuilding will facilitate the carrying out of the four-course in all its details.

Personal Notes.

DR. WM. DAVID BOWEN, '93, was married Jan. 19th to Miss Orpha Hackney at Wilson, N. C.

DR. M. W. HADDAD, '97, sent a Canadian one dollar bill from Beyreuth, Syria, for the Journal.

DR. J. D. POINDEXTER, '86, has been ordered to Manila. He has been in the regular army over ten years.

DR. T. F. GODFREY, '98, has been practicing in Boston. He is now in Baltimore taking a post-graduate course.

DR. L. GIBBONS SMART, '85, has been secretary of the Baltimore County Medical Association since its organization in May, 1897.

DR. J. E. GOLLEY, '96, is doing well in his profession at Templeville, Md. He is examiner for the New York Mutual Life Insurance Company.

DR. V. L. TODD, '90, who was Professor of Chemistry and Toxicology in the Columbian Medical College of Kansas City, Mo., died Dec. 22d.

DR. PEARL WILLIAMS, '96, after spending over a year in Europe has located in Providence, R. I. He has made a good start and his prospects are excellent.

DR. A. ST. GEORGE, '95, of Fall River, Mass., was in Baltimore for a few days in February. He sailed for Europe February 25th to spend a year in post-graduate work.

DR. LOUIS D. LeBONTE, '94, is at Derby, Conn. Recently he was elected City Health Officer; he is also a member of the Board of Education and Surgeon to the City Fire Department.

DR. A. G. ALDRICH, '79, after spending much time in post-graduate courses both in this country and in Europe has located in Minneapolis, Minn., and is limiting his practice to diseases of the Eye, Ear, Nose and Throat.

DR. C. H. BANGS sends the menu of the Annual Banquet of the Lynn Medical Fraternity. On it is printed this excellent sentiment: "The way to get on in the world is to keep your mouth shut and your bowels open."

DR. W. W. HUME, '89, was several weeks at the City Hospital with a sprained ankle. He is practicing at Quinnemont, W. Va. From him we learned that Dr. J. G. Haley, '89 and Dr. George O. Quesenbury, '87, are at Hinton, W. Va.

DR. J. J. SNYDER, '93, is an assistant surgeon in the navy. He was the third man appointed April 25th. He spent some time on the Cuban blockade, was two months in Porto Rico and is now stationed on the receiving ship Wabash at Boston.

DR. C. D. J. MACDONALD, '97, is located in Norfolk. He has been employed by the city doing vaccine and inspection work during the

recent smallpox scare. Since being relieved from this duty he has gone to New York to do some post-graduate work.

DR. J. J. CHAMBERS, '84, located in Dawson City in the spring of '96 before the great rush to the gold fields. He has had charge of the hospital there, has been practicing, and owns some good gold claims. He will return to the gold fields in April.

DR. HARRY FRIEDENWALD, '86, has gone to Europe to spend four months. He spent three years abroad studying diseases of the Eye and Ear before he began to practice. The time during this present trip will be devoted to the same special line of work.

MRS. M. M. GUNDRY, widow of the late Dr. Richard Gundry, has opened a sanitarium at Catonsville, Md., for a limited number of female patients suffering from mild forms of mental disease. Dr. Lewis H. Gundry, '90, and Alfred T. Gundry, '94, are associated with her.

SOUTH BETHLEHEM, PA., February 21, 1899.

DR. WM. J. TODD, Baltimore, Md.

Dear Doctor.—Enclosed find my subscription for the JOURNAL and my best wishes for its success. It certainly reflects great credit on its promoters, and doubtless will do much towards keeping the boys in touch with one another. Last week we organized a medical club in Bethlehem, upon invitation of Dr. H. J. Laciari, '81; he gave us a "crack-a-jack" banquet of ten courses (floating) among those who joined were H. J. Laciari, '81, P. O. Wickert, '82, F. H. Erwin, '88, and C. W. Laciari, '93; this club is therefore strongly P. & S. and as it is social as well as scientific in its tenets, we always have the "latch-key hanging out" for "P. & S." boys.

Yours truly,

F. H. ERWIN.

WORCESTER, MASS., Feb. 9th, 1899.

DR. H. FRIEDENWALD.

Dear Doctor.—I practised in Millbury, Mass., from the time I graduated till the summer of '97 when I went to New York, taking

a course in the N. Y. post-graduate. I then returned home only to locate in Worcester, Mass., where I am now practicing and doing well. I have been here about one year and feel that I have made a good change. My country practice was large and hard, so that by coming here I felt that I was having a larger field, over 100,000 people, but less territory to cover.

I will endeavor to be present this year at your exercises in spring.

Fraternally,

H. W. CRONIN.

GREENEVILLE, TENN., November 12th, 1898.

DR. WM. J. TODD.

My dear Doctor.—I have been receiving the JOURNAL of the Alumni Association of the College of Physicians and Surgeons and appreciate it very much. I will remit my subscription soon.

I give you herewith mention of a few alumni not heretofore mentioned in "personal notes."

Dr. S. W. Horn, '91, is located at Childress, Tenn., and is enjoying a good country practice. He will be remembered by the members of the class of '91 as the "old man."

Dr. W. J. Matthews, '92, is located at Johnson City, Tenn., and is doing well. He is a member of the Board of Pension Examining Surgeons and was for several years City Physician.

Dr. C. H. Saunders, '91, is conducting a pharmacy at Chase City, Va.

Dr. J. R. Boyd, '93, is at Oakvale, W. Va., and is recognized as one of the best physicians in his section of the State.

Dr. Bruce Clark, '91, is living in Pulaski county, Va., and is devoting his time to agriculture and stock raising.

Dr. Sam'l P. Pearis, '92, of Princeton, W. Va., died of appendicitis soon after graduating.

Dr. Chas. R. Shumate, '93, is practicing at Bluff City, Va.

Dr. J. R. Boyd, '77, died in Greeneville, Tenn., in 1890. He was one of the leading physicians in East Tennessee and was esteemed by all. He had been very successful and had accumulated considerable property.

Dr. F. L. A. Wilson is located in Bluefield, W. Va. Dr. H. C. Jones is there also.

As to your humble servant, he is doing well in the "gem city" of East Tennessee. I have a large obstetrical practice and am physician to the Jail and County Poor Asylum.

Fraternally,

S. WALTER WOODYARD, Class '91.

PATERSON, N. J., October 10th, 1898.

W. J. TODD, M. D.

My dear Doctor.—I herewith acknowledge receipt of two copies of the ALUMNI JOURNAL, and take great pleasure in enclosing check for subscription.

The two copies alone in my possession have been the means of providing me with the addresses and location of several old college chums and classmates.

The College of Physicians and Surgeons is very dear to me, and the recollections of college life in Baltimore is fondly cherished. I have had the pleasant opportunity of meeting several of the "boys" of '94 during the past year or so, and all are presumably doing well; in fact, I am beginning to think that "failure" is impossible with the P. & S. graduates.

Dr. F. E. Knowles, Dr. Lockwood, Dr. Davis and Dr. Day are all enjoying a good practice, and all Jersey boys too. My preceptor, Dr. Thos. L. Paton, class '87, is one of our most prominent and respected physicians.

As regards myself, I feel that I have no cause to complain. Besides enjoying a good practice, I am also Medical Examiner for the Metropolitan Life Ins. Co. of New York, Examiner for the Improved Order of Heptasophs, of which Dr. J. H. Christian of Baltimore is Supreme Medical Director, and several other organizations. I am Visiting Physician to the Nursery and Child's Hospital, New York, a very large and extensive institution.

I also received last week the Republican nomination for Coroner of Passaic county, New Jersey, comprising a population of about 200,000 people, and am almost confident of election.

So you see the P. & S. boys are not lagging behind by any means. Drs. Knowles, Lockwood and myself have determined to be present at your next annual meeting, all being well.

Wishing you every success in your undertaking, and with highest regards for my old instructors, I remain,

Yours very sincerely,

HERBERT S. EMERSON, '94.

SIDE-LIGHTS ON ARMY LIFE DURING OUR LATE UNPLEASANTNESS; CULLED FROM THE LETTERS OF MR. CHARLES J. HALPER.

By CHAS. E. BRACK, M.D.

(Continued from Volume I, No. 4.)

TAMPA, FLA.—We left Chickamauga Thursday at 6 A. M., marched eleven miles and waited until 4.30 P. M. Then took train and, after a long and disagreeable ride, arrived here Sunday night at 8.30 P. M. Our company was detailed to guard the train all night.

We are in a place built for mosquitoes and sand fleas. Every time you put your foot down it sinks two feet in the sand. Thinking of Pimlico reminds me of the song: "Put your feet in the mud, stick them in the sand."

Our tents are not like those at Pimlico; they are only about four feet high in the centre and open in front. They are built for two, and when you have crawled in at night you lay there with your feet sticking out until morning. They are called dog tents, and when they speak of bringing forth the dogs of war I wonder whether they mean us or the tents.

I hope I will never see another pig when I get home, for the South just swarms with them; they run about the streets with the same privileges as the dogs, and besides we have bacon three times a day.

To-day is Sunday, and we have been very busy washing our clothes and ourselves. I wash myself every half hour, and then am as bad as if I had never washed, on account of the charcoal in the sand.

When we drill fire darts from under our shoes.

Tampa resembles Atlantic City, but has not as many hotels. The Tampa Bay Hotel is magnificent and is the headquarters of Gen. Miles and staff.

I comb my hair by looking in my cup of coffee, which is the best we can do as looking-glasses are a luxury.

The box sent by the boys received with thanks. Since yesterday all I have done is eat, eat and eat.

The captain asked me about the box, and I told him it had gone to sleep, the sleep of eternal rest, but he could not see it in that light, and I had to open up.

We all feel very bad this afternoon, as at 5 P. M. our company goes out to bury one of the boys, who was accidentally shot by a comrade. The government allows but ten dollars for a private's funeral, and we collected enough to make forty dollars. The government furnished the ground and ambulance, and of course we had our chaplain.

We went over to Yabor City this morning; this town reminds me of Meeter's on a large scale. There are a number of cigar factories here run by northern capital; a large number of Cuban young men and girls are employed. One hears almost as much if not more Spanish spoken on the streets than English. Every man you meet smokes a cigar except the soldiers—they are content with their pipes.

Yesterday while in town I purchased a washing board and pail and am now one of the millionaires of the camp. Paderewski is not in it with me when I sit down to play.

My father sent me two pair of white pants and a fiver. I still have the pants and the memory of the V. When I came out of my tent in those ducks there was a tremendous yell, and all the boys stood at attention as I passed down the line.

It is just as hot as ever, and while white ducks are cool it is too hot to wash them. I am now in the hospital corps and have every thing packed ready to leave the 5th.

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Vol. II

No. 2

JULY, 1899

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REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

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Personal Notes.

DR. JAMES McMANUS, '85, Lindly, N. Y.

DR. J. F. ANDEBSON, '85, is practicing at Cornucopia, Ga.

DR. W. M. SIVEY, '94, is practicing at Tunnelton, W. Va.

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Personal Notes.

DR. J. W. JOHNSON, '85, Davis, W. Va.

DR. S. A. STONE, '86, died of apoplexy March 30, 1899, at Monongah, W. Va.

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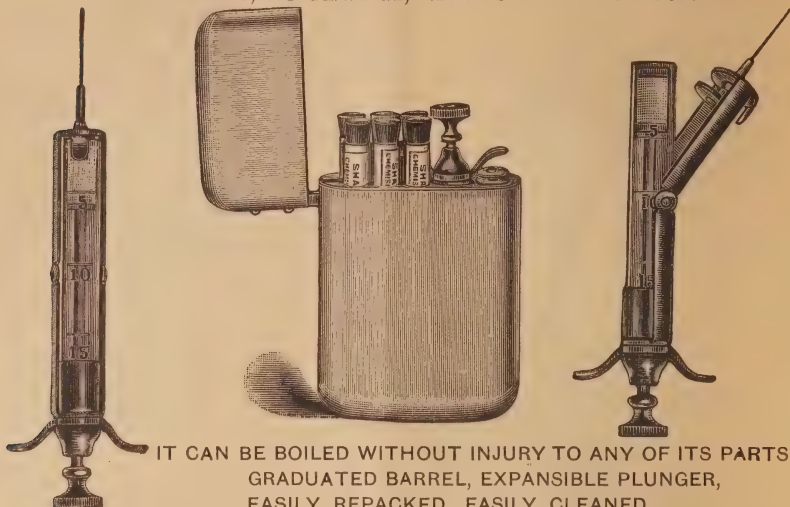
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THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

THE NEW COLLEGE BUILDING.

At the opening of the session in October the College of Physicians and Surgeons of Baltimore will present to the student one of the most modern structures ever erected in this country for instruction in medicine. It has been the aim of the faculty to be strictly up-to-date, and nothing has been left undone in order that that aim shall be accomplished. A special committee from the faculty was appointed some months ago to visit the large medical centers, to view the colleges in these cities and thus secure an accurate knowledge of latest methods that have been adopted and found beneficial in the instruction of the medical student. The institutions of New York, Boston and Philadelphia were inspected and all the good points from these colleges were studied, and after much labor and careful consideration plans for the new college building were agreed upon.

In order that the very latest appliances could be obtained and that the minutest detail in every department would not be neglected, the faculty has expended \$100,000 in the construction of this building.

As has been said, the dominant idea in the building of the structure is that it shall be modern in every respect, and to this end the greatest care has been given to the equipment of the laboratories and class-rooms wherein the practical side of medicine will be taught.

The building is to consist of four stories. On the first floor is to be found the Dispensary, which is so divided that each specialty of medicine has its separate room. That the student of medicine may understand the advantages this Dispensary furnishes, it need only be mentioned that last year alone there were treated nearly 30,000 patients. On the first floor also is found the heating, lighting, cold storage and ventilating machinery of the building.

The second floor is to contain two large class-rooms, the Clinical Laboratory, where the members of the graduating class are to be instructed in the clinical methods of diagnosis, the Pasteur Laboratory and Library. This Library is to be made a special feature. The apartment devoted to it is commodious and well lighted, and is to be furnished with medical, standard as well as current literature, so that the student will have every opportunity of availing himself of a solid foundation in medical knowledge.

The third floor is to have two amphitheatres, Clinical Laboratory, Pathological Laboratory, Physiological Laboratory and Chemical Laboratory, toilet and accessory rooms. The amphitheatres on this floor are to be well lighted, special efforts having been directed in this line, and are to be sufficiently large to accommodate the student comfortably during the lectures and demonstrations.

On the fourth floor the apartments are specially constructed for the demonstration of clinical work. On this floor is to be found an amphitheatre that will seat 400 students, and the arrangements have been so made that even with the hall filled to its fullest capacity, each individual will have an unobstructed view of every operation. Those who have attended colleges built upon less modern plans can readily appreciate what this means. Each student can, without any inconvenience, see over the heads of his neighbors and observe the operations in comfort. Adjoining this main amphitheatre is to be found a number of rooms for sterilization, anæsthetizing, dressings and operations of minor character. On the fourth floor is also located a Bacteriological Laboratory that will be second to none in its equipments to give the medical student an intimate understanding of this most important branch of modern medicine.

The Anatomical Department is commodious, well lighted, conveniently arranged and abundantly supplied with material.

The new College Building, as was the old, is directly connected with the City Hospital, which has also been enlarged. The advantages of this arrangement can very readily be appreciated. The hospital is filled at all times with medical cases of interesting character, and, on account of the central location of the hospital in the city of Baltimore, the accident department keeps the surgical wards well filled with instructive material.

Every effort will be made to give the student a practical education. Not only will the clinical material be brought before the class, but bed-side instruction will be insisted upon. On these occasions the professor of the particular branch will be in charge and under his supervision the student will be required to bring out all the important points of the case and will be taught to cultivate his observing qualities.

With all the advantages of Clinical and Bacteriological Laboratories open to the student, and with the valuable opportunities to observe the progress of cases at the bed-side, nothing is omitted that would give the seeker of medical knowledge an advantage to thoroughly equip himself and thus make him a competent practitioner.

In conformity with the modern methods that have been adopted at the College, a Training School for Nurses has been established at the City Hospital. Working in conjunction with the Sisters of Mercy, the efficiency of the hospital has been increased, and in this way the ward teaching has been materially facilitated.

The result of this painstaking labor on the part of the faculty has been to give the student advantages that cannot be excelled. Practical instruction has not been neglected by giving an excess of theory, nor has theory been neglected to the extent of giving a faulty foundation. The methods that have been adopted are those that have been thoroughly tried and found to give the medical student the greatest advantages that can be derived from a four years' course in the study of medicine.

E. V. M.

A CASE OF RETRO-CALCANEAL BURSITIS (ALBERT'S DISEASE).

BY DR. HARVEY G. BECK, '96.

The true nature of this disease, quite often encountered, of pain in the region of the insertion of the tendo Achillis, with broadening of the heels and a marked tendency towards the development of pes planus, was not generally recognized until 1892, when Prof. Albert of the University of Vienna reported one of a half-dozen cases of this disease that occurred in his experience under the name of Achillo-dynia (*Wiener medicinische Presse*, 1892, No. 2). Previous to his report no reference on this subject can be found in literature. Albert refers to Raynal and Kermissin, who described a "peritendinous cellulitis of the tendo Achillis," and a description in Pitha-Billroth's *Handbook of General and Special Surgery* of a "partial evulsion of the insertion of the tendo Achillis," in which the symptoms correspond in a striking manner to those that characterize this disease. To Augustus A. Eshner of Philadelphia belongs the credit of reporting the first case in this country. This case occurred in the service of Dr. Hare at the Jefferson College Hospital, and his article was read at a meeting of the Philadelphia County Medical Society, February 8, 1893, and published in the *Medical News*, 1893, LXII, 187.

Da Costa has had under his personal charge in the Jefferson College Hospital since the report of Eshner's case 8 cases, which he studied carefully from an ætiological and pathological standpoint, as well as that of treatment, and published his results in the *Philadelphia Medical Journal*, Vol. I, No. 11, page 469, under the title of "Bursitis of the Retro-calcaneal Bursa," recognizing that the causative condition exists in the form of an inflammation, acute or chronic, in the retro-calcaneal bursa and not in a partial rupture of the tendon or evulsion of bone as Albert was led to believe or in trophic disturbances, to which others attributed the cause.

The Bursa is interposed between the os calcis and the tendo Achillis directly above its insertion; is heart-shaped, normally the size of a quarter of a dollar, containing a small quantity of clear viscid fluid. The walls are made up of fibrous tissue lined with endo-

thelium; some cartilage is found in the walls, and from it osteophytes may develop, which occasionally appear in the bursal sac and aggravate the condition.

Rössler found in 225 dissections of the bursa that it is rarely normal in the adult. It may contain considerable thick fluid; the walls may be thickened and cartilaginous; there may be periostitis or hypertrophy or atrophy of periosteum, etc. (*Deutsche Zeit. f. Chir.*, Bd. 42, H. 3, 96).

I have had the opportunity to see a case in my own experience which I report here:

A woman, æt. 28, single, came to me a year ago with the history of having suffered for two years with "chronic Bright's disease" associated with "heart disease," and also has had rheumatism. Her sister told me that the physician in charge secretly informed the family that her condition was perfectly hopeless and that she could not live very much longer. To use her own expression: She had tried all the medicines in the apothecary except that in the show bottles without any relief whatever. Patient was a stout, well-nourished, healthy-looking individual, of good color, weighing 170 lbs.

Her occupation was that of a laundress, chiefly ironing and pressing with a heavy (6 lb.) iron. This required a stooping attitude, throwing her body forward and transmitting almost the entire body weight on her toes.

Family history unimportant. Has no specific venereal history; no alcohol. Had usual diseases of childhood. At age of 13 had typhoid and a year later a very severe attack of rheumatic fever; since then she has had periodical rheumatic pains involving mainly the larger joints, until the onset of her recent illness two years ago, when she began to complain of much pain on the inner side of the right foot below and in front of the internal malleolus and in the heel, which was associated with decided swelling, increasing the circumference of the foot at the ankle two inches. An attempt to walk would set up most violent pains. During the two previous years she had not walked a distance exceeding five squares at a time. When in recumbent posture, she could not rest her heel in bed on account of the pain produced by the weight of the foot.

In ascending or descending stairs she stepped on the heel of the right foot, as it provoked less suffering than by stepping, as one naturally would, on the toe, except during periods of greatest intensity, when she would proceed on her hands and knees.

Physical examination of heart and lungs proved negative. Repeated examinations of the urine revealed nothing to suggest any form of nephritis or other structural lesion. On account of the pain, she acquired a limping gait which resulted in a tilting of the pelvis, producing a rather perceptible deformity. On inspection the heel seemed unnaturally broad. A distinct swelling existed on each side of the tendon near the insertion; this was somewhat tender on pressure. Fluctuation was present. Passive flexion of foot would produce some pain. Patient rising on toe would produce intense pain, which was promptly relieved by rest. A very marked degree of flat-foot was present; the plantar arch was entirely obliterated. About a year ago ether was administered by Dr. Ewing, a free incision made on the inner side of the tendon through the skin and fascia, when the bursal sac bulged prominently into the opening and the fluid contents could be definitely ascertained by palpation. The sac was opened, and several drachms of an opaque, slightly yellowish, viscid fluid escaped. The walls appeared thickened, but no osteophytes were present. The bursa was curetted, swabbed out with pure carbolic acid and drainage applied, which was left in 24 hours. Suture was removed the eighth day. The wound healed partly by granulation. In four weeks pain disappeared on walking and has not had a recurrence since. A flat-foot spring was recommended, with a stiffening in the inner shank of the shoe, which not only afforded her much comfort, but has almost entirely corrected the deformity. Patient gained 15 pounds in the last year. She married some months ago and now attends to her household duties, besides conducting a steam laundry.

The following is a summary of the cases I found on record, including my own, and is intended to show the factors entering into the ætiology of the disease, the treatment and its result. Gleaning the facts in these cases one will see at a mere glance that sex, age and occupation figure very prominently as predisposing causes; that over-exertion, injury and specific infectious diseases are notable exciting causes, although the latter may be predisposing as well as exciting.

No.	Sex.	Age.	Occupation.	Ætiology.	Pes Planus.	Treatment.	Result.
1	M.	40	Clerk (standing.)	Overwork.	Slight.	Operation.	Cured.
2	M.	23	Motorman.	Overwork.	Slight.	Operation.	Cured.
3	M.	14	Schoolboy.	Scarlatina.	Absent.	Ichthyol.	Cured.
4	M.	31	Storekeeper.	Overwork.	Double.	Ichthyol and flat-foot spring.	Cured.
5	M.	28	Fireman.	Injury.	Present.	Operation.	Cured.
6	M.	32	Fireman.	Influenza.	Absent.	Ichthyol, rest and com- pression.	Cured.
7	F.	23	Housemaid.	Calcaneal caries (?).	Present.	Operation.	Unimproved— results not so good on ac- count of caries.
8	M.	35	Policeman.	Gonorrhœa.	Slight.	Ichthyol.	Cured.
9	M.	22	Car Cleaner.	Overwork (?).	Present.	Eshner's case; does not mention treatment.	
10	F.	28	Laundress.	Rheumatism and over- work.	Very marked.	Operation.	Cured.

Sex.—It appeared in 80 per cent. of these cases in the male, probably for the reason that their occupation tends more favorably to bring about this condition.

Age.—Occurred from the age of 14 to 40; in 80 per cent. between the age of 22 and 35—in the most active period of life.

Occupation.—This is perhaps the most important factor that pre-disposes to the disease. It will be observed that in nearly every instance the occupation required one to be on the feet almost constantly, and more than that, the whole weight of the body to rest on the toe, thus exerting a most extraordinary strain upon the tendo Achillis, which in all probability has some influence in bringing about a state of congestion in the adjacent bursa, and if the irritation is maintained, it may ultimately result in an active inflammation. In 40 per cent. of the cases no other ascribable cause was to be ascertained. The other cases were apparently due to scarlatina, injury, influenza, calcaneal caries, gonorrhœa and rheumatism. It is clearly evident that infectious diseases have a decided ætiological bearing.

Tuberculous bursitis has occurred; four cases have been reported

by Weisinger, upon which he operated (*Deutsche Zeit. f. Chir.*, Vol. XIVIII). It is doubtful whether the inflammation can arise from syphilis. It occurs as an acute or chronic bursitis. In the acute form the walls are slightly thickened, fluctuation is generally present, tenderness is produced by digital pressure, passive motion and by rising on the toes. There is a dull aching pain when patient is at rest. In the chronic form the walls are very much thickened and may be cartilaginous; fluctuation is rarely present. There is little or no pain on passive motion or digital pressure, but rising on toe excites intense suffering. The heel is broadened and flat-foot invariably exists.

Osteophytes, when present, can be detected by the X-rays. It must be diagnosed from thecitis of the tendo Achillis and simple flat-foot. In thecitis the pain is referred upward along the tendon, developed by passive motion and upon rising upon the toes. There is distinct grating on movement. The heel is not broadened. In flat-foot there is pain on walking, which is relieved by rest; no undue sensitiveness at the insertion of the tendon; no enlargement of the bursa or broadening of the heel. The treatment resolves itself for acute cases in rest, compression, inunctions of ichthyol, and when there is much effusion into the sac, aspiration or incision. Chronic cases may yield to the same treatment.

Frequently they require incision and drainage, and it is deemed best to destroy the sac.

Osteophytes must be removed when found to exist.

Since writing the above another case has come under my care. The history and symptoms are briefly as follows:

Lady, æt. 43, married, weight 175, is engaged in doing general housework.

Family history negative. Gives an indefinite history of rheumatism years ago. Had malaria when 11 years of age, and over a year ago sustained an injury to left foot which resulted in a slight inversion.

At the onset of present illness, 6 months ago, the patient, when walking or standing, suffered from considerable pain in the right foot directly above the insertion of the tendon, which gradually continued to get worse. On examination a distinct bulging on either side of the tendon is found which gives to the heel a somewhat broadened appearance, and from which a sense of fluctuation can be elicited.

Flat-foot is tolerably well-marked.

Passive flexion excites intense pain.

Patient rising on toe produces the same character of pain.

By digital pressure a well-defined area of local tenderness can be outlined. This area is limited to the tendon itself near its insertion and extending forward a few centimeters on either side.

This lady resided in a third-story flat prior to the onset of her disease.

Failure to recognize a cause in the nature of an infectious disease or injury, we again have to attribute it to overwork. It undoubtedly is induced by the effort thrown on the tendon in going up and down stairs where we have the prime factor come into play, namely, standing or stepping on toe.

No treatment has yet been instituted.

700 E. Chase Street.

ADDITIONAL POINTS ON THE RELATION OF ADENOIDS TO EAR TROUBLE.

BY DR. FRANK DYER SANGER, '88.

In an article published in Vol. I, No. 11, of the JOURNAL of the Alumni Association, On the Importance of Recognizing Hypertrophy of the Pharyngeal Tonsil, I endeavored to call attention to the necessity of investigating more carefully the condition of the vault of the pharynx under certain circumstances.

I am daily becoming more and more convinced of the dangers which lurk in enlargement of the lymphatic tissue in the nasopharynx. When we contemplate how few children who have adenoids escape ear complications, varying in gravity from simple tinnitus through many grades of deafness to deaf-mutism, embracing all forms of suppuration from otitis media acute to prolonged suppuration in attic or mastoid antrum, bearing in mind at the same time the fact that the relation between adenoids and the ear trouble is in many cases not casual but causal, we begin to realize how important it is for some one to know the condition of every child's nasopharynx.

We need more statistics upon the subject to show how common adenoids are. Their frequency has been variously estimated by different writers. Meyer, for instance, found them in one per cent. of the two thousand school children he examined in Copenhagen. Schmeigelow later in the same city, found five per cent. in children of higher grades and thirteen per cent. in children in lower grades. Wroblewski found seven per cent., Kafemann nine per cent. respectively in children examined by them, and so on. But the number of statistical reports needs to be greatly increased before any really valuable deductions can be made.

The examination of the naso-pharynx with the finger at birth should become a routine practice. When we become sufficiently aroused to the necessity of systematic medical supervision of our public schools one of the great benefits will be the detection of neglected adenoid cases, which will be the means of saving many ears, and will not infrequently solve the problem of deficient mentality which has baffled the most conscientious teacher.

Statistics to show how common ear troubles are among children with adenoids are abundant and convincing. In Meyer's early report of one hundred and two cases, seventy-two had ear trouble. Urbaschitsch found one hundred and thirty ear cases among one hundred and seventy-five persons with adenoids. Swenburne twenty-seven in forty-two cases. One writer makes the astonishing statement that not more than five per cent. of patients suffering from adenoids escape ear complications. This is possibly an extreme view, but such statistics as those of Meyer and Urbaschitsch may be considered to represent fairly the facts of the case, coming as they do from a throat and ear authority and having been collected in cities distant from each other—Copenhagen and Vienna.

Frankenberger, of Prague, who quotes the above statistics and many more to show the relation of adenoids to ear disease, has made a most thorough investigation of the inmates of the Deaf and Dumb Institute in his city, and found that among one hundred and fifty-eight cases examined, ninety-four or fifty-nine and forty-nine hundredths per cent. had adenoids. Similar observations by Wroblewski in Warsaw gave practically the same percentages—fifty-seven and

five-tenths. Frankenberger also examined the statistics from various sources to show the proportion of congenital to acquired deaf mutes. He further reviewed Mygind's very careful investigations regarding the pathology of deaf-mutism and came to the conclusion that congenital deaf-mutism is not so common as was formerly supposed; that the cause may reside exclusively in changes in the middle ear, and that in a large number of cases adenoids are the cause. He is of the opinion that adenoids not only interfere with the ventilation of the ear, but also favor the extension of inflammation to the middle ear, especially at times when infectious diseases are present, following which deaf-mutism is notoriously frequent.

Children whose faucal tonsils are chronically enlarged are undoubtedly more subject to repeated attacks of acute inflammation of these structures and hence are predisposed to diphtheria and other infectious fevers liable to attack the throat. In the same manner adenoids predispose to these diseases, becoming at the same time inflamed and taking on new growth during the course of such diseases as diphtheria, scarlet fever, etc.

There is also strong evidence to show that these tissues in many instances harbor tubercle bacilli, if indeed the tissues are not themselves tubercular. And it is quite possible, as Brieger has pointed out, that this is the starting point of tuberculosis of the middle ear. It is possibly also a more frequent portal of entry of tuberculosis into the glandular structures of the neck in young life than is generally supposed. It is therefore important that the naso-pharynx be examined under these various circumstances, and the proper measures taken to prevent further infection or a spread of the infectious process. Dr. Lennox Brown advocates the removal of adenoids even in the acute stages of the infectious diseases. It is certainly wiser to watch the naso-pharynx with the finger than to watch the drum membrane for the first appearance of pus, as is so often recommended in the treatment of scarlet fever.

If adenoids are such a menace to the ear as statistics would indicate, their presence in very young children should not be tolerated unless the child can be kept under the strictest supervision, and even then the risk seems entirely too great, since it is out of all proportion to

the danger of removing them. In every case in which adenoids are complicated by ear trouble, thorough removal should be accomplished without delay, irrespective of age or other circumstances. It is a grave error to defer operation in older children when the adenoids are giving trouble in the hope that nature will relieve the condition. Dr. Lennox Brown speaks of the hope that leads to delay as a "fool's paradise." Dr. Grenville Macdonald says that spontaneous atrophy at twenty will not give as good result as operation at eighteen. If this is true the statement gathers force as we descend the age scale from 18 to —. Within a few days I have operated on an infant seven months old with a double otitis media, soft adenoids being removed with the finger nail.

Hypertrophies which do not cause trouble in older children may sometimes be left to nature; but never enlargements, which are producing mischief and especially mischief in the ear.

THE CO-EXISTENCE OF FIBROMYOMA AND CARCINOMA IN THE UTERUS, WITH A REPORT OF THREE CASES.*

BY DR. W. WAYNE BABCOCK, JR., '93.

From the former belief in the malignant epithelial degeneration of the benign connective-tissue tumor, a more modern tendency has arisen to consider these two classes of growth as entirely distinct and as without interdependence. While we no longer believe in the carcinomatous degeneration of the myoma, the co-existence of myoma and carcinoma in the same organ retains a clinical and pathological interest that seems to be frequently ignored.

A study of three very recent cases, in which these tumors were associated, has prompted this reference to the association in the uterus. Even admitting, with a recent author (Kelly, "Op. Gyn.," Vol. II, p. 381), that this association in the uterus is merely a coincidence and that the growth of the one tumor is without influence upon the growth of the other; a sufficient interest remains from the diagnostic stand-

* Read before the Philadelphia Obstetrical Society, by invitation, October 6, 1898.

point alone. But it is with a feeling that we should not too hurriedly abandon the older view that fibromyoma may predispose to carcinoma in the uterus that the following cases are presented. They are from the practice of Dr. Charles P. Noble, to whom I thankfully acknowledge indebtedness for the privilege of their study and report.

As we especially desire to emphasize the association, and as the neoplasms obviously present structural features similar to those found in the unassociated growths; an elaborate pathological description is deemed unnecessary.

Briefly the cases are as follows:

Case I.—Miss E. T., white, American, æt. 60; had lost her mother and sister from cancer of the uterus. She had menstruated regularly and had passed the menopause at 51. Two years ago a slight leucorrhœa, straw-colored, was noticed, which became more profuse and was nearly constant; but apparently was never very offensive. For this she was ineffectually curetted last year and again this. The scrapings were reported to be cancerous.

An abdominal panhysterectomy was performed September 9, 1898, from which the patient is now convalescent.

The specimen shows a uterus somewhat enlarged by the presence of an interstitial fibromyoma in the fundus, which measures four and one-half by three cm. The uterine cavity is enlarged, excavated and shows irregular papillary projections from the endometrium. The cervix and appendages appear to be uninvolved.

The microscope shows the endometrium of the body to be ramified by irregular ocini of the glandular type which are irregularly lined or choked with cells of the columnar pattern.

The ocinous epithelial invasion is more pronounced near the uterine cavity, but involves the adjacent uterine tissue. Round-cell infiltrations and areas of extravasated blood are to be noticed, the latter a probable result of the preparatory curetting.

The diagnosis is adeno-carcinoma of the corpus uteri, associated with interstitial fibromyomata of the fundus.

Case II.—Mrs. M. H., white, American, æt. 63; a multipara, had passed the menopause and was vigorous until about one year ago, when irregular hemorrhage from the vagina and uterine pain developed and proved progressive.

Physical examination showed a large, unhealthy cervix, a fungus mass filling the os and bleeding upon pressure. A diagnosis of cancer was made; but inefficient infiltration was found in the broad ligaments to preclude hysterectomy.

The cervix was therefore removed by the curette and cautery, this procedure unfortunately opening up the cul-de-sac of Douglas. The patient sank under the operation and two days later died.

The uterus was removed post-mortem and was found to be moderately enlarged. Inferiorly it shows the rough, irregular surface where the diseased mass was scraped away. On section a small globular submucous fibroid 1 cm. in diameter was found near the internal os.

The microscope shows an invasion of the remains of the cervix and lower uterine tissues by compact, irregular masses and strings of cells of the squamous epithelial type. The cells are markedly irregular in size and in staining capacity.

Areas of intense round-cell infiltration, in places invading the capsule of the fibromyoma, are present. An epithelial invasion of the benign tumor, a condition which had been recorded a number of times, is not observed.

Diagnosis.—Squamous epithelioma of the cervix uteri, associated with a small submucous fibromyoma.

Case III.—Miss B. H., æt. 48, English; had lost an aunt of carcinoma and two sisters of phthisis. The patient, though much overworked and overworried during the past ten years, had passed the menopause and had enjoyed good health until one and one-half years ago, when a hemorrhagic discharge from the vagina developed and progressed. Two months ago it became offensive. Severe bearing-down pains radiating from the inguinal regions down the legs were associated. An obstinate insomnia was present.

On September 15, 1898, the patient was etherized and the uterus curetted. The curette entered the uterus to the depth of four or five inches. A large amount of material was removed. The individual scrapings being irregular, large (frequently one or two centimeters in diameter), rather firm and fibrous, and of a pale, grayish yellow color.

The clinical diagnosis was sarcoma or degenerative fibromyoma.

The microscope, however, revealed the typical alveoli of adenocarcinoma, separated by a moderate amount of stroma.

A panhysterectomy was performed September 22, 1898, after renewed curetting. After a severe illness of eight days the patient died. A post-mortem was not had.

The uterus is decidedly enlarged, being about twelve cm. in length and six cm. in breadth. The fundus is occupied by a fibromyoma about four cm. in diameter. Below this is the large red, rough and excavated cavity of the uterus. The entire cavity apparently being lined by infiltrated tissue, much of the diseased tissue has of course been removed by the vigorous curettage.

Diagnosis.—Diffuse adenoma-carcinoma of the uterine body, associated with an interstitial fibromyoma of the fundus.

It will be noticed that two of these three cases showed the comparatively rare cancer of the body, and only one the common epithelioma of the cervix. That this is not exceptional is shown by others. Jassett (*Cancer of the Uterus*, p. 73) states that adeno-carcinomas are frequently associated with fibroids. He gives the history of two patients with uterine adeno-carcinoma, one of whom, a multipara, had co-existent fibroids. Williams (*Cancer of Uterus*, pp. 83-93) describes seven cases of cancer of the body of the uterus, two of which showed associated fibroids, while in a third case a uterine polyp had been removed five years before. In one of the cases the epithelial growth had penetrated the fibroid.

Stone (*N. Y. Med. Journ.*, July 27, 1895) gives four cases of malignant adenoma of the uterus in which the uterus was inspected. One of these cases had associated subperitoneal and interstitial fibroids. Kelly ("Op. Gyn.," vol. II., p. 380) refers to a review of one hundred cases of uterine carcinoma, in eight of which myomas were co-existent. Of the eight, six were adeno-carcinomas of the body, one an adeno-carcinoma of the cervix and but one an epithelioma of the cervix. With this we should consider the relative infrequency of carcinoma of the body. Schroeder (*Hofmin Zeitschrift f. Geb. v. Gyn.*, Bd. x) estimated that only 3.4 per cent. of uterine cancers originate in the corpus. The results of Cullen's examination of sev-

enty-six of Kelly's cases of uterine cancer are recent and appear to more accurately express the relative frequency. Of the seventy-six cases (Kelly, "Op. Gyn.," vol. II., p. 311), fifty-two (68.4 per cent.) were epitheliomas of the cervix, thirteen (16.8 per cent.) adeno-carcinomas of the cervix, and eleven (14.4 per cent.) adeno-carcinomas of the body of the uterus.

If we believe with Garrigues ("Dis. of Women," p. 454) and others, that twenty per cent.* of all women over thirty-five have uterine fibromyomata it is to be expected that a certain per cent. of these women, along with others, will develop the prevalent uterine cancer. The association here being a mere coincidence. To maintain, however, that the association is always coincidental requires an explanation of the apparent great preponderance of the association with the comparatively rare corporeal carcinoma over the association with the very common cervical epithelioma. Although adeno-carcinoma of the body usually occurs somewhat later in life than the latter, we have little reason to think that fibromas originate after the menopause. The fact that both fibromas and adeno-carcinomas of the body of the uterus are common in the nulliparous would explain in part; yet both affections are sufficiently common in the multiparous to make the explanation seem but partial. With the insufficient statistical data at hand there yet seems to be a sufficient suggestion that fibromyoma may predispose to adeno-carcinoma of the corpus to urge the study and the record of other cases. On the other hand, there is little to suggest that the epithelioma is associated other than by coincidence with the benign tumor.

The endometrical changes, especially the glandular hyperplasia pointed out by Wyder and Von Compe (*Archiv f. Gyn.*, B. xxix, p. 318, 1887), and the vascular and the mechanical irritative effects produced in the uterus by the presence of fibroids would appear to lend color to the theory of a predisposition in the former case.

Diagnostically the error is usually the unimportant one of overlooking the benign tumor. Occasionally, however, the hemorrhage and discharge is ascribed to the fibroma alone; the carcinoma being

* Penrose in five hundred and four coeliotomies found seventeen per cent. of fibroids. Penrose, "Dis. of Women," p. 233.

unsuspected. This error is of course more liable to happen with carcinoma of the body, and it has led to such operations as myomectomy, the removal of the appendages alone, the extirpation of uterine polypi and other futile procedures. Kelly mentions four instances of this error ("Op. Gyn," vol. II., p. 311). Its possibility indicates the importance of a routine examination of the endometrium, removed by the sharp curette or otherwise, in all cases of elderly women who have fibroids with symptoms, especially if these be associated with discharge, odor, or other suggestion of malignancy.

I think we may conclude:

1. That the frequency of association of fibromyoma with adenocarcinoma of the corpus uteri, is greater than would be, a priori, expected and relatively much greater than with the more common epithelioma of the cervix.

2. That a coincidence of the two growths is favored by their individual proneness to affect the nulliparous; but that the frequency of the association seems greater than is thus explained, or than is explained by the frequency of fibromyomas in all uteri after middle life.

3. That the endometrial hyperplasia and the congestive and irritative influences produced by fibromyomas would seem to favor the development of the malignant tumor.

4. That further investigation is desirable before the old theory that fibroids predispose to cancers in the uterus is considered as disproved.

5. That the occasional serious errors of diagnosis from this association render the routine examination of the endometrium desirable in elderly women with fibroids and imperative when there is excessive or odorous discharge, or abundance of scrapings.

3626 N. Broad Street.

CONCUSSION WITH COMPRESSION OF THE SPINAL CORD.

BY DR. R. PERCY SMITH, '91.

In presenting such a theme to you for discussion to-day I do not for a moment imagine myself capable of teaching this learned body

anything on this subject, nor do I undertake to advance any new theories, but merely to call your attention to some practical points that may at some future time be of value to you in your practice. The country practitioner, unlike his city brother, is called upon to treat all classes and conditions of mankind, while our city brethren usually send all surgical cases to a surgeon, and so each separate class of their patients is sent to a specialist in that particular branch. Our facilities for such not being great, we are compelled to be equipped and ready to receive each case as we encounter them in our daily walks, from the extraction of an offending tooth to the amputation of a leg, or performing craniotomy on the living child. In fact, we have to be as the Poet Saxe says: "Be ever ready to rely on yourself!" The country physician, therefore, might properly be termed a general specialist. Therefore, if each of us would only carefully keep notes of cases of interest occurring in our practice and give our members the benefit of such experience, it would prove not only interesting, but of inestimable value to us all. The chief object of our association is mutual benefit, and while theories are always necessary and indispensable as the root of our practice, still nothing is quite so interesting to a busy general practitioner of medicine as practical points pertaining thereto. This idea, and this alone, prompts me to write up from notes carefully taken at the bedside of my patient the subject which I to-day present for your consideration.

During the afternoon of June 28, 1897, our worthy ex-president (Dr. Piper) and I were hurriedly summoned to the bedside of Harry M——, aged sixteen years, a student at the Hopkins University, who, while spending his vacation at his country home, had accidentally gotten beneath a large harpoon hay fork (an implement used by farmers for unloading their hay wagons) loaded with probably four hundred pounds of loose hay. Just as the fork had gotten back to its proper position to discharge its contents, the lad was unfortunately in a stooping position, and totally unaware of the death-trap at that moment overhanging him. The next instant the trap was sprung and the boy crushed to the floor below. Willing hands were present, and at once set about to release the imprisoned boy. When taken out he complained of no pain whatever, but there was complete ina-

bility to move any member of the body. Upon our arrival we made a thorough examination of our patient, and found complete paralysis of all parts below the fifth cervical vertebræ. We at once had a room prepared on the lower floor, and the patient carefully removed to his bed where hot applications were applied to the sides and extremities, the room darkened, and everything made strictly quiet. Our diagnosis was concussion with probable compression of the spinal cord, although no fracture of the vertebral column could be detected even by repeated and most careful examination. We at once asked for and obtained professional nurses that every possible assistance might be given the sufferer. The following morning after the accident local sensibility had so far improved that the prick of a pin to the soles of the feet would cause a decided reflex. We then hoped there was only concussion causing temporary paralysis, and to unload the portal circulation we ordered doses of calomel and soda every two hours until four doses were administered. That afternoon we secured a copious evacuation, well formed, and his temperature dropped in a short while from 102.4 to 100, with the result that he was far more comfortable, and the condition of the pulse improved. The following morning we secured another evacuation well formed, without the use of any drugs. The pulse remained at eighty, but the temperature went up to 102.28, where it remained for twenty-four hours. At this time we ordered frequent sponging with ice caps applied both to the head and neck constantly. The temperature began to descend at once, and by observing clinical chart No. 1, an interesting feature here occurs, in that the thermometer used every hour shows a fall of about five degrees hourly, until at 10 P. M. the temperature was registered at 96.2 and the ice caps removed. Then the temperature began to climb again as rapidly as it had descended, and at 7 A. M. the following morning the thermometer showed 101.3°. The ice cap was again ordered, and light nourishment given every few hours of milk or animal broth. No reflex was longer obtainable. As the fever continued to increase we ordered in addition to the caps a spinal ice bag, and gave ergot m. xv. By 5.30 P. M. the temperature had again dropped to 99°, pulse 76. We then called Dr. I. E. Atkinson, of Baltimore, with us in the case. He was unable to say positively

or locate any compression, and thought, with such local treatment as we were using—ergot occasionally, and milk with egg albumen or beef juice at regular intervals—we were doing all that could be done for our patient. On the fourth day his condition remained unchanged; temperature varied so decidedly that the ice cap and spine bag would frequently have to be replaced by hot bottles, and vice versa, according to the conditions as they arose. Towards evening the heart became so depressed that I gave strychnia, gr. 1-40 hypodermically, and obtained a quick response. At 9 P. M. the temperature again arose to 103° , and we decided to use wet cups over the site of probable spinal compression, drawing four ounces of blood. This seemed to relieve the patient considerably, as a comparatively quiet night was spent with very little muttering. The morning of the fifth day at 3.30 A. M., the pulse became very feeble and slow, only 54 per minute. A hypodermic of strychnia 1-50 gr. was given, followed in an hour by brandy. At 9 A. M. a large quantity of bloody discharge issued involuntarily from the mouth. Strychnia was again given at 11 A. M. and brandy at 12. The remainder of the day was uneventful. On the morning of the sixth day the patient's mind was clear, he asked for breakfast and talked rationally. The catheter was passed several times daily, and nine ounces of urine evacuated. Mastication seemed fairly good. At 6.15 P. M. Dr. L. McLane Tiffany saw patient with us, but declined to operate as compression was not certain beyond a doubt. The seventh day was uneventful until the afternoon when cardiac syncope and collapse became so decided that death seemed imminent. A hypodermic of strychnia followed in half an hour by two of brandy, with a hot water bag over the heart and to the extremities, relieved this condition until 9 P. M., from which time a constant watch had to be kept on the patient the entire night, as the phrenic nerve or center of respiration seemed involved, and breathing would at times cease for many seconds. Artificial respiration was occasionally resorted to with remarkably quick benefit. The heart would then flag and nitroglycerine was used hypodermically gr. 1-100. The morning of the eighth day found our patient sinking rapidly, and in spite of strychnia and atropine hypodermically, with artificial respiration, death closed the scene at 11.25 A. M., after

many days of the gamest fight for life, but most unequal struggle, I have ever witnessed.

The immediate cause of death was evidently extension of inflammation from the seat of injury to the base of the brain, which probably occurred the previous afternoon at 4 P. M. when collapse appeared imminent, as above related. The assistance we received from our nurses was of the highest order, being faithfully and conscientiously performed. Theirs was a part well done, and while ours may not have been remarkable for skill, it was the best that in us lies, and at the close of the chapter we felt a sense of gratification in believing we had no sins of omission or commission to regret during our guidance of the case.

From my experience in this case, I have drawn one decided conclusion for my future guidance, should it ever be my fortune or misfortune to encounter such another. It was the prognosis of us all from the first that the patient must succumb. Why then should we not in such cases cut down upon the vertebral column and look for the depressed fracture or possibly blood clot causing the compression? The patient may perchance die on the operating table or soon after removal; still this should be no argument against operation. To withhold the knife will be catering to death, to use it may possibly rob death of a victim. We at least give our patient one chance in a hundred by radical procedure, without it we give him none. I trust none of you present may very soon encounter so grave a case, but if you should I would advise you to apprise the family of the circumstances, and either operate yourself or uncompromisingly insist upon having it done, thereby giving your patient the one chance to which he is entitled.

TREATMENT OF SYPHILIS.

BY DR. HARVEY P. JACK, '91.

I have originated what I call the blood-washing treatment in cases of malignant syphilis, and I believe that this method of treatment has a wide field, not only here, but in any condition in which toxins are circulating in the blood current.

Realizing that the treatment of syphilis by the well-established methods is very satisfactory, a cure resulting in 98 per cent. of all cases, yet I think there remains much to be desired in point of time in mild cases and in point of efficiency in malignant ones.

With the end in view of ascertaining its efficiency, I have tested this plan of treatment in two classes of cases: 1st, malignant syphilis in a patient not too far reduced to endure the treatment; 2d, in robust, promising to be severe, cases with the idea of ascertaining if it shortens the time and lessens the symptoms in the latter.

It is of course too early to predict anything definite for this plan of treatment, but the results have been apparently so striking that I report these cases in the hope that the method will be thoroughly tested by those who have better opportunities for observing its effects and on a larger number of cases.

The method consists in the withdrawal of from one-half to one pint of blood from the arm by the usual method at intervals of one or two weeks, being replaced at once by twice the quantity removed of a hot normal salt solution made under nipples, in which solution was placed a sufficient quantity of mercury bi-chloride to make a solution of the strength of 1-25000. For three days after the treatment the patient is kept in bed, though this is not necessary always, and forced feeding with milk according to S. Weir Mitchell's plan begun; at the end of three days the patient is allowed to get up and be about but still requested to drink all the milk he can digest. This plan of treatment was repeated six times in three cases, when they were put upon appropriate treatment, mixed treatment for late cases, and proto-iodide or biniodide for the early ones. This treatment by mouth was kept up six weeks and stopped, the cases being still kept under observation. During the milk-diet treatment the ox-gall compound pill, according to the formula of Prof. Wm. P. Porter of New York City is given as a digestive and laxative. It has long been known that very small quantities of mercury, if introduced directly into the circulation, manifested remarkable power in early curing syphilis, but here we do infinitely more. The first case on which this method was used was a very malignant one. In spite of thorough treatment for a period of one year by a very competent physician, this case

was in a horrible condition. His septum nasi was gone, he had localized paralysis, ulcerations on the shin bones and periostitis, and all this in spite of the fact that he was receiving large doses of pot. iodide, fifty to sixty grains, alternately pushed and stopped for two weeks at a time, and one-half gr. biniodide of mercury in addition three times daily without intermission. After satisfying myself of this man's condition and finding that his treatment (he having also had one-sixth gr. bi-chloride of mercury hypodermically for the last three weeks of his treatment every third day, and inunctions having been given), diet and hygiene had been for a year all that could be desired, according to the established and usually very efficient methods, I determined to try the procedure detailed above. Accordingly, one-half pint, eight fluid ounces, of blood was withdrawn (from) and immediately replaced by the mercuric salt solution injected hot, and the patient instructed to remain in bed for three days on a milk diet, which was pushed as already described. In addition, he was given for the week intervening before his next injection, beginning the third day, one dram of the following prescription three times daily:

R Hydrarg. Biniodidi.....	gr. iss
Pot. Iodidi.....	℥ ii
Amon. Iodidi.....	vi
Tr. Gentian Comp.....	q. s. ℥ iii

At the end of one week this procedure was repeated, the bleeding and injection, the prescription by mouth being discontinued for three days. At the end of another week the method was followed up and so on for six weeks, when the patient was put on the above prescription for eight weeks and all treatment stopped for a time, though the case is yet under observation, and, if considered necessary at a later day, the above prescription or some other combination or preparation of the specifics will be given by mouth.

Almost at once this wreck, weighing at the beginning of treatment 110 pounds, began to improve rapidly. After the bleeding was stopped he rapidly laid on weight, gaining thirty-eight pounds in thirty-eight days. This was three months ago, and he still remains perfectly well, having resumed his occupation, which is an arduous one. How much of this happy result was due to the rest in bed

for three days out of each week for three weeks, and how much to the injections it is impossible to say. Both contributed to the result, and I desire that the milk diet be considered a part of the method, although it is not new.

I may say, however, that the regulation egg-nog forced feeding had been resorted to in his case and was being used at the time I was consulted, and also that in the other cases in which the method was used and which were not put to bed and the feeding forced, the gain in weight was almost as remarkable, one case gaining twenty pounds in thirty days, so that I think we have a right to conclude and not doubt it will be readily admitted that the blood-washing was the principal factor in these results.

Encouraged by the improvement in the malignant cases, I have recently tried this method in two cases of recent syphilis which promised to be severe. The result has so far been all that could be desired, neither case manifesting a single symptom of the disease since the injections, which were three. As remarked above, it has long been known that very small doses of mercury controlled syphilis if introduced directly into the blood current, but here we do this, the large bulk of the hot-salt solution aiding the absorption of the drug and preventing the formation of albuminate of mercury in the tissues, and wonderfully more because we remove poisons from the blood and replace this toxic blood with an antiseptic specific capable of stimulating immediately all the secretions to a remarkable degree, and this in six weeks of this treatment. Extracting a pint of blood each week, we are capable of largely purifying the blood current, manufacturing new blood and securing a healthy reconstructive metamorphosis, which I believe will terminate in the cure of our patients in proper cases in a much shorter time than we are capable of bringing it about by any other means. The results are so striking, and the theory so logical, founded as it is on fact and common sense, that I hope the method, for which I believe so much, will be thoroughly tested for the benefit and to the benefit of suffering humanity.

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THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

THE STANDARDIZATION OF DRUGS.

The value of a definite strength for each preparation of all drugs is so obvious that it seems childlike to offer an argument in favor of it. The condition of the mind that opposes standardization is beyond comprehension. It is sincerely to be hoped that the committee of revision will fix some definite standard, either chemical or physiological, for every preparation of every drug, where it is possible, which is to be included in the forthcoming edition of the Pharmacopœia. The standard should be in all possible instances a chemical one; but it is well known that there is great difficulty to be encountered in fixing a definite standard from the chemical composition of some of the drugs in most frequent use; for example, ergot. That, however, is no excuse for leaving every pharmacist free to mix up a solution of smut and call it Fluid Extract of Ergot. If the chemist fails, as he has in ergot and in some other very useful drugs to determine the special constituent that produces the physiological effect, then let the experimental pharmacologist point the way by a physiological test.

By all means let every physician, when prescribing, insist on having drugs supplied that have been standardized either chemically or physiologically.

ANNUAL ALUMNI MEETING.

The annual meeting of the Alumni Association was held April 18, 1899, Vice-President Dr. H. S. Jarrett in the chair.

The class of '99 were elected to membership.

Dr. Sanger reported that the executive committee had made the necessary arrangements for the annual banquet.

The treasurer's report was read and referred to a committee for auditing.

Dr. Todd reported that the JOURNAL committee had published five numbers of the JOURNAL; that the JOURNAL had paid for itself and had a small balance to its credit, the greatest need at present being enough subscribers to entitle it to entry at the post-office as second-class matter. The subscription list is constantly growing.

The following officers were elected for the ensuing year. President, Dr. J. Gorse Simmons, '91, of Brooklyn, N. Y.; 1st Vice-President, J. W. Malone, '88, of Brooklyn, N. Y.; 2d Vice-President, Dr. Standish McCleary, '90; Secretary, Dr. A. W. McGlaunan, '95; Treasurer, Dr. C. E. Brack, '95; Assistant Secretary, Dr. M. Ekstromer, '99; Chairman of Executive Committee, Dr. H. Friedenwald, '86.

Dr. J. W. Chambers, '78, was appointed a committee of one to secure the money and have painted a portrait of the late Dr. Geo. H. Rohé, for presentation to the Medical and Chirurgical Faculty of Maryland. Any one wishing to assist this fund can send their contributions direct to Dr. J. W. Chambers, 18 W. Franklin Street.

The alumni banquet this year was the most successful and enjoyable one held for many years. Every one who went had a good time, and all who heard about it afterward have been groaning on account of their absence. Next year there will be another banquet and a larger attendance, and the Bacillus Club guarantees that there will be even greater enthusiasm. Now let every one of the boys who missed this last banquet make preparations to be present at the next.

The following are some of the visitors from out of town who did not miss the good time: Dr. Brooks, '84, Sunbury, N. C.; S. M.

Free, '80, Dubois, Pa.; J. G. Simmons, '91, Brooklyn, N. Y.; J. W. Malone, '88, Brooklyn, N. Y.; Thomas H. Brayshaw, '85, Glenburnie, Md.; H. J. Jarrett, '84, Towson, Md.; E. W. Steeves, '98, Moncton, Canada; F. W. Lockwood, '93, East Orange, N. J.; Francis E. Knowles, '93, South Orange, N. J.

Personal Notes.

DR. J. B. FALLMER, '84, is at Rohersburg, Columbia county, Pa.

DR. STUART M. MANN, '95, has a flourishing practice at Myock, N. C.

DR. R. A. WALKER, '82, is at Shea, Pa., in the gas belt. He is doing well.

PROFESSOR THOMAS OPIE, M. D., has removed his office to No. 1121 Madison Avenue.

DR. J. FRANK RUTHERFORD, '92, has removed from Bestop, Pa., to Albuquerque, N. M.

DR. A. E. HEILMAN, '84, has a good practice in the coal-mining district at Rural Valley, Pa.

DR. EDWARD H. EWING, '97, was married to Miss Agnes K. Kennedy at Philadelphia, June 20th.

DR. C. BANKS McNARY, '93, of Crescent, N. C., recently brought a patient to the Pasteur Department.

DR. J. M. PATTON, '85, has been practicing at Kelly's Station, Armstrong county, Pa., but does not expect to remain there.

DR. CHAS. W. WAINWRIGHT, '87, has been elected secretary, and Dr. Monmonier Rowe, '81, treasurer of the Somerset County Medical Society.

DR. G. E. ROBISON, '98, in a recent letter relates briefly a considerable number of interesting surgical cases he has had in his practice at Provo, Utah.

DR. U. O. HEILMAN, '81, is the leading physician in Leechburg, Pa. In addition to his general practice he is doing special work on the nose and throat.

DR. GEO. B. McREYNOLDS, '98, is Resident Physician at the Presbyterian Eye and Ear Hospital, Baltimore. He is the first man from the college to obtain this position.

DR. HARRY FRIEDENWALD, '86, has returned from his trip to Europe. The first part of his time was spent in Berlin, and after visiting a number of the other German clinics, he divided his last month between London and Edinburgh.

DR. A. W. McGLANNAN, '95, was married June 14th to Miss Anna M. Crean of Baltimore. The ceremony took place at the Cathedral, Cardinal Gibbons officiating. Among the ushers were Dr. Standish McCleary, '90; Dr. John Ruhrah, '94; and Dr. Alan W. Smith, '95.

At the meeting of the American Medical Association at Columbus, a number of the alumni met and talked over old times. Among them were H. M. Hazleton, '93, New Straitsville, O.; James Gass, '91, Sheffield, Pa.; L. F. Ankrum, Pittsburgh, Pa.; C. I. Wyche, '93, Yonkers, N. Y.; C. W. Petty, '93, Hartford, W. Va.; J. H. Ray, '85, Coalton, O.; A. S. Grimm, '85, St. Mary's, W. Va.; William S. Gardner, '85, Baltimore.

DR. A. M. WHISNANT, of the class of '93, is a very successful practitioner, and is located at Carolee, N. C. Since his graduation he has traveled extensively throughout the states and has taken many special courses, the last one being at the Post Graduate Hospital in New York City last winter.

DR. G. W. TYRRELL, the boon companion of Dr. Whisnant, is located in Perth Amboy, N. J., where he has been practicing since graduating in '93.

In 1894 Dr. Tyrrell was appointed health inspector at a salary of \$600 a year for one year. In 1895 he was reappointed for another

year. In 1897 he was appointed city physician for a term of three years.

The doctor is examiner for very many insurance companies and societies, prominent among which may be mentioned the New York Life, the Hartford Life, the Massachusetts Benefit Life, and four different "Courts of Foresters."

The doctor has been married nearly five years, having taken for his wife one of the ladies he met in Baltimore.

His sojourn in Baltimore having proved so fortunate to him, he endeavors to visit the place at least once a year and invariably calls at the hospital.

SUMMERSVILLE, WEST VA., May 22, 1899.

DR. W. S. GARDNER, Baltimore, Md.

Dear Doctor Gardner.—Enclosed find my subscription for the JOURNAL of the Alumni Association of the College of Physicians and Surgeons.

It comes to me like a visit from an old friend bringing both good and sad news.

It was with sadness that I read of the death of that noble man, Prof. Geo. H. Rohé. The P. & S., as well as the Alumni, sustains a great loss in the death of Dr. Rohé. I have just finished framing his picture and have it hanging in my office, and when I look at it, it brings to my mind many pleasant recollections of my college days at the P. & S. I have been conducting a good and successful practice here since my graduation in '94. Am health officer for the county, and medical examiner for the New York, Equitable and Mutual Life Insurance Companies of New York.

I have just returned from attending the annual meeting of the West Virginia Medical Society which met at Weston. While there I had the pleasure of meeting quite a number of the P. & S. boys, amongst whom were Dr. C. C. Hershman, of Pittsburg, Pa.; Dr. J. W. Kidd, of Burnsville, W. Va.; Dr. R. H. Powell, of Grafton, W. Va.; Dr.

L. L. McKinney, of Burnsville, W. Va.; Dr. W. H. McCauley, of Sutton, W. Va., and Dr. Mark Perry, of Greenbrier, W. Va., and who is assistant physician in the West Virginia Hospital for the Insane at Weston.

Wishing you every success, and with the highest regards for the P. & S. and my old instructors, I remain,

Yours fraternally,

J. E. RADER, '94.

DR. J. W. MALONE, '88, Brooklyn, N. Y., writes:—"I am happy to say that I have prospered since graduation. I have a large and lucrative practice, besides holding several positions of trust. I am surgeon to the Nassau Electric Railroad of this city, and also one of the medical examiners of the Mutual and Equitable Life Insurance Companies for the city.

"I hope, through the JOURNAL, I may hear from some of my old classmates."

GLOUCESTER, OHIO, April 18, 1899.

W. J. TODD, M. D.

Dear Doctor.—I take pleasure in enclosing check for subscription to your valuable JOURNAL. I will always have pleasant recollections of college life in Baltimore. I am enjoying a first-class practice in a town of 3,000 inhabitants. I am medical examiner for the Manhattan of New York, U. S. of New York, Germania of New York, and the Odd Fellows of Piqua, Ohio.

I am also railroad surgeon of the T. & O. C. and K. & M. railroads. Would be pleased to hear from some of the classmates of '95.

Wishing you success, I remain,

Yours very sincerely,

A. B. ALLEN, '95.

DERBY, IOWA, March 5, 1899.

DR. WILLIAM J. TODD, Baltimore, Md.

My Dear Doctor.—I often wonder where all the members of our class are, 1881. I have never met one of them since we graduated.

I located here the fall after graduating; have been in continuous practice; have done well. Dr. L. A. Beers, of 1880, is located at Gray, Iowa; is doing well. Dr. William Stumbaugh, '97, is located at Ackworth, Iowa; has a good practice. It seems as though all the men from the C. P. S. are hustlers and get their share of the good things of life.

Yours, etc.,

W. E. MOORE, M. D., '81.

WARM SPRINGS, MONTANA, June 1, 1899.

DR. W. S. GARDNER, Baltimore, Md.

* *Dear Doctor.*—Please note the above as my new address for the JOURNAL. I reached here Tuesday and assumed my official duties as 2d assistant to-day. Dr. O. Y. Warren, '85 (P. & S.), is the medical superintendent and has entire and complete control of the institution. Dr. W. A. Wickline, '95 (P. & S.), is the 1st assistant. We are the only three physicians at the institution. The asylum has 480 patients, 2,200 acres of land, large buildings, and has its own cattle, horses, steam plants, water works (from natural hot springs), etc. We are 25 miles from Butte and 10 from Anaconda. This is a lovely valley surrounded by high, snow-capped mountains, and pierced by a small river. My regards to your wife and all the boys.

Yours,

J. M. SCANLAND, '97.

SIDE-LIGHTS ON ARMY LIFE DURING OUR LATE UNPLEASANTNESS; CULLED FROM THE LETTERS OF MR. CHARLES J. HALPER.

BY CHAS. E. BRACK, M. D.

(Continued from Volume II, No. 1.)

FERNANDINA.—This town reminds me of Milford with its broad streets lined on either side by old elm trees. The people are very courteous, the town having a population of 2,000, two-thirds of whom

are black. The beach is about a mile from the camp and one of the finest on the coast.

Some of the bands here are fine, especially the one with the 5th Ohio, and we get all the music we want.

We are on the top of a little hill with our large hospital tents in one line, then separated and facing about twenty feet distant come first the dispensary tents and stores and back of them are the officers' quarters. Directly in front of us is the lighthouse and the keeper's dwelling, while surrounding us are all the different regiments.

This evening a number of Fernandina's most prominent ladies came to visit the sick. They not only brought sunshine to the poor fellows under our care but to us as well.

If the mosquitoes would only give us time to breathe could not wish for anything better.

Our hospital is full: 81 cases of measles from the 1st Fla. and about 15 cases of fever. If they can't stand their own climate how can they expect us to.

There are three saloons here and they have two bars, one for the whites and the other for the blacks; the former get ponies, the latter schooners.

I want to distinguish myself like that fellow did in India. I have it all figured out: As soon as I get out in the firing-line I am going to pick up a fellow and run like blazes; if they hit any one they will hit the other fellow, and my name will go down in history as a hero.

I was on duty last night, and while nursing in the army may be all right, I would rather be back studying anatomy.

My tent is a sight; on one side is a sign "fresh bread," on the other "Drink Fla. Brewing Co.'s Beer," on top a Cuban flag and inside a lot of hay; the latter is my bed. I had a cot once, but some one else has it now; I wish I knew who. It is a case of take your bed and go.

We have a great scheme to get out of doing work. There are typhoid patients' blankets on the fence, and behind them swings my hammock, so that I cannot be seen from the steward's tent. Behind the typhoid germs the nurse serenely sleeps.

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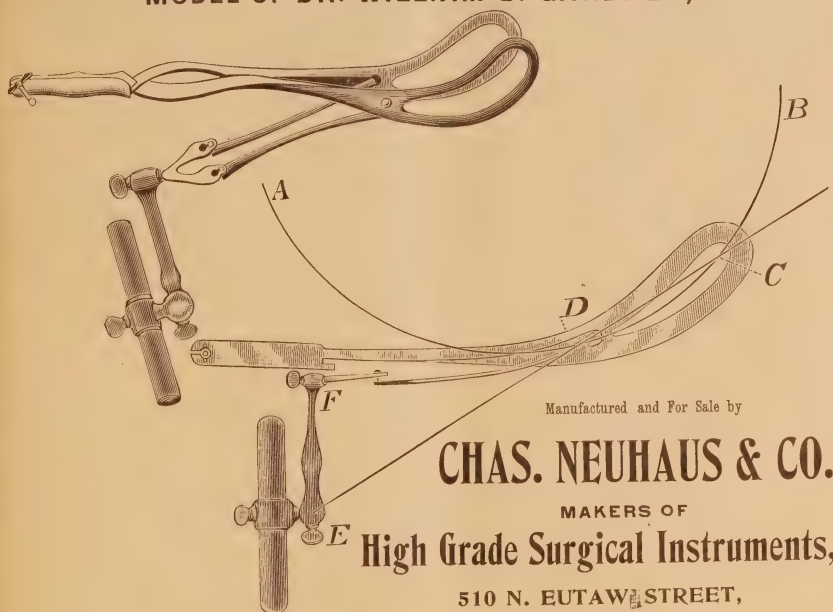
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Personal Notes.

DR. I. H. WHITE, '95, is practicing at Knoxville, Pa.

DR. JACOB A. BAIRD, '78, is now practicing at Dunlo, Cambria County, Pa.

DR. T. G. HAMRICK, '95, is physician to the Henrietta Mills at Caroleen, N. C.

DR. NELSON F. HALL, '86, has removed from Fulton, N. Y., to Minneapolis, Minn.

DR. WILLIAM J. TODD, '89, has been elected President of the Baltimore County Medical Association.

DR. W. P. STONE, '93, died of tuberculosis at his home at Lydonsville, Va., July 29, 1898, aged 28 years.

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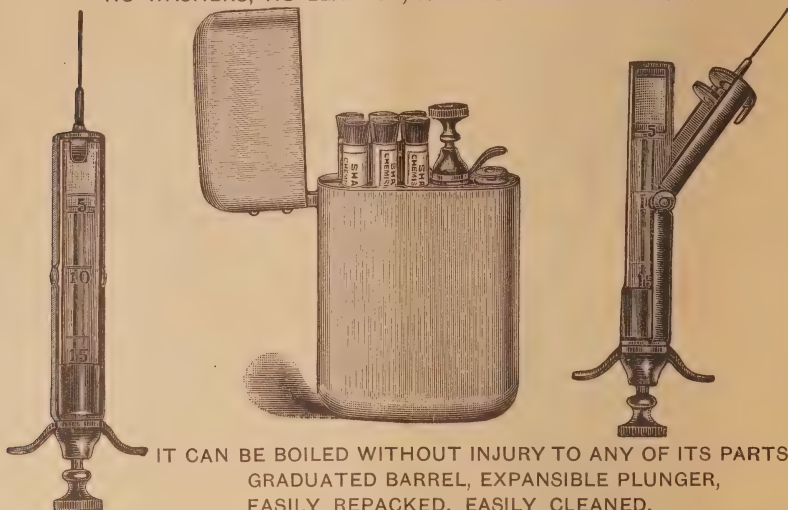
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ON THE USE AND THE ABUSE OF NITRATE OF SILVER
IN THE TREATMENT OF OPHTHALMIA OF
THE NEW-BORN.

By DR. HARRY FRIEDENWALD, '86.

During the last few years a number of new remedies and new methods of treatment of ophthalmia of the new-born have been brought before the profession and extolled in terms of highest praise. As yet I have had no experience with them, for I have continued to use and rely upon the *nitrate of silver*, and I see no reason to discard it. In treating an affection, the favorable result of which is of such importance throughout the life of the individual, it seems reckless to experiment when we possess a remedy which, properly applied, almost guarantees success.

The prophylactic treatment is as nearly perfect as can be hoped for in things medical. Howe* has shown "that previous to the introduction of Crede's method the records of over 17,000 births tabulated by thirteen observers showed that over nine per cent. of the children developed ophthalmia neonatorum. On the contrary, after the introduction of Crede's method, the records of over 24,000 births, tabulated by thirty-one observers, showed only 0.65 per cent. In other words,

*Transaction Am. Oph. Soc., 1897.

the proportion was nearly 15 times more frequent without the Crede method than with it." The experience of those connected with our Maternité Hospital in Baltimore thoroughly accords with the above.

But the treatment must be carried out properly, in strict accordance with Crede's method. The solution to be used is a *two per cent. solution*, and a single drop is to be instilled directly upon the cornea as soon as possible after birth. It will not do to either increase or decrease the strength of the solution. Thus Howe's study has shown that a *one per cent. solution* reduces the percentage of ophthalmia only to 2.4 per cent. or about four times that of the standard solution.

The effect of stronger solutions and their more abundant use may be very disastrous, as is demonstrated by the following case: Last year I was called to see an infant that had been born at 4 A. M. Soon after birth *several drops of a three per cent. solution* were instilled and in the early forenoon an attendant, believing that the treatment had not been used, instilled some more. The eyelids rapidly swelled and when I saw the child there was a large infiltrated area, embracing the lower half of the cornea, and presenting the typical picture of a burn of the cornea. Under simple treatment (boracic acid salve) the inflammation subsided and the cornea cleared up to some extent. This was evidently not a specific ophthalmia; its onset, course and its appearance proved it to be a burn from the nitrate of silver.

In hospital practice no one questions the propriety of applying Crede's method. In private practice it is rarely used. Is it not almost criminal neglect not to use it when the mother is known to have gonorrhœa or even when this disease is suspected? The conscientious physician, who does not apply it in cases of severe leucorrhœa or when the mother has previously borne children that suffered with ophthalmia, will find it difficult to relieve himself in his own mind from blame if the infant he delivers develops ophthalmia.

We now come to the curative treatment of ophthalmia of the newborn with nitrate of silver. Here it is equally important to apply the remedy properly, but it is much more difficult, for accurate judgment is required and hard and fast rules cannot be given. The solu-

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THE MEDICAL SUMMARY.

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thusiastic as to use it to the exclusion of other tried remedies in all forms of malarial toxemia. Dr. Ben Brodnax, of Brodnax, La., one of the most gifted physicians of the south, and certainly the most ingenious therapeutist in the land, goes so far as to say that it may be used in the treatment of pernicious intermittent fever, to the exclusion of all preparations of cinchona. That gentleman also says that he has abandoned quinine in all malarial cases, and intimates that it is an etiological factor in the production of malarial hæmaturia or swamp fever. The Doctor says he has never failed to cure any of his cases with the acetanilid, and that he never has any blood in the urine of his patients. This I am constrained to believe is a mere coincidence, as we are liable to see cases of malarial hæmaturia when the patient will affirm that he has

man with good common horse sense would. Would you dare rely on the acetanilid to obviate a recurrence of this dreadful paroxysm? Can you positively affirm that it has any antiperiodic properties? If there is an element of uncertainty in the case, why not give him a remedy with well established antiperiodic action, and one that will have a favorable effect on the pathogeny of the disease? We have such a remedy in quinine, and the majority of cases yield promptly. The physiological action of acetanilid bears a striking resemblance to the algid form of pernicious intermittent fever, with the exception of coma, and for that reason we think it is clearly contra-indicated in this and some other cases of malarial disease. It may do well in hyper-pyrexia of ephemerical fevers, but it should never be given in continued fevers with a marked tendency to ady-

The nitrate of silver is to be used once daily, and after the first

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THE MEDICAL SUMMARY.

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thus as to use it to the exclusion of other tried remedies in all forms of malarial toxæmia. Dr. Ben Brodnax, of Brodnax, La., one of the most gifted physicians of the south, and certainly the most ingenious therapist in the land, goes so far as to say that it may be used in the treatment of pernicious intermittent fever, to the exclusion of all preparations of cinchona. That gentleman also says that he has abandoned quinine in all malarial cases, and intimates that it is an etiological factor in the production of malarial hæmaturia or swamp fever. The Doctor says he has never failed to cure any of his cases with the acetanilid, and that he never has any blood in the urine of his patients. This I am constrained to believe is a mere coincidence, as we are liable to see cases of malarial hæmaturia when the patient will affirm that he has

men with good common horse sense would. Would you dare rely on the acetanilid to obviate a recurrence of this dreadful paroxysm? Can you positively affirm that it has any antiperiodic properties? If there is an element of uncertainty in the case, why not give him a remedy with well established antiperiodic action, and one that will have a favorable effect on the pathogeny of the disease? We have such a remedy in quinine, and the majority of cases yield promptly. The physiological action of acetanilid bears a striking resemblance to the algid form of pernicious intermittent fever, with the exception of coma, and for that reason we think it is clearly contra-indicated in this and some other cases of malarial disease. It may do well in hyper-pyrexia of ephemeral fevers, but it should never be given in continued fevers with a marked tendency to ady-

Favorite Prescriptions.

We hope that our readers will take special interest in this department of the SUMMARY. We solicit practitioners to furnish us for publication with one or more of their favorite prescriptions. Only such as your personal experience has convinced you to be of practical use should be submitted.

Formulas plainly written on a *postal card* is a convenient way for sending. Always give them in this order, please:

1. Name of the disease.
2. The formula and directions.
3. Your name, town and state.

Reader, let us hear from you in time for the next issue of the SUMMARY.

Inflamed Throat, Tonsils, Etc.

Editor Medical Summary:

The following combination is a very pleasant application for an inflamed throat, tonsils, etc:

R. Con. tr. bryonia (Kieth & Co),
 Con. tr. gelsemium.....aa 3 j
 Camphor gum.....3 j
 Coal Oil.....3 fi

Phosphoric acid.....3 j
 Fld. ext. rhus tox.....3 ss

M. Sig.—Teaspoonful every three hours; four doses a day.

R. Ol. cajuput.....3 ss
 Ol. olive3 ij

M. Sig.—Apply locally and rub thoroughly.

TOOTHACHE.

For a patient who had been suffering intensely for sometime, caused by more than half a dozen of snags in his jaws, advised extraction, but refused and wanted relief; I prescribed:

R. Fld. ext. gelsemium.....3 ij
 Fld. ext. belladonna . . . gtt. xij
 Quinine Sulph.....gr. xv
 Tr. gentian comp.,
 Syrup simp.aa 3 ij

M. Sig.—Teaspoonful every two hours; at longer intervals as the pain grows less.

THE FOLLOWING HAS PROVED ITSELF AN AD-
 VANTAGEOUS COMBINATION IN THE TREATMENT OF

M. . Sig.—Teaspoonful every two hours;
at longer intervals as the pain grows less.

Editor Medical Summary:

W. K. Harris, M. D., McLoud, Okla.,
sends the following:

B. Muriated tr. iron,

Bal. copaiba aa ʒi 160

Shaker's elixir malt and aro-
matics.....q. s. ʒ viij

M. Dose, one tablespoonful four times
a day.

Mucilage of gum arabic may be used in
place of the Shaker's Elixir. The Doctor
says it does good work in bladder troubles
of old men. The two first drugs are rub-
bed in a mortar till well mixed, and the
others added, triturated till mixed.

BEN H. BRODNAX.

Brodnax, La.

Paralysis—Toothache.

Editor Medical Summary:

I hereby contribute my mite to your
“Favorite Prescription” column, and in
the first place will give you the formula
that has cured several cases of wrist drop
—paralysis of the extensor muscles of the
forearm:

B. Fld. ext. ergot.....ʒ j

The following has proved itself an ad-
mirable combination in the treatment of
that troublesome affection, asthma:

B. Fld. ext. grindelia robusta,

Syr. hydriodic acid (Hostelley)

.....aa ʒ ij

M. Sig.—Teaspoonful in water ever
three or four hours.

W. C. BUCKLEY, M. D.

723 Berks St., Philadelphia, Pa.

Note.

Several practitioners write us desiring
the experience of others with the Wood-
bridge treatment in typhoid fever. Will
those who have had experience with this
particular treatment please write it out
for the SUMMARY columns?

Notice!

Reader, please send us your favorite
treatment for diphtheria, pneumonia,
bronchitis, typhoid fever, etc.

are given to retrospection, they must occasionally revert to the time when malarial diseases were so very fatal. After we began to treat these cases with quinine very few deaths resulted, and these patients were all of the pernicious variety. Can we afford to abandon a remedy used with such success for a half century? I think not.

Let us submit a hypothetical case for the advocates of acetanilid to consider, and we hope that Dr. Brodnax and others will give the matter their attention: Suppose we are called to treat a case of pernicious intermittent of the algid variety; this case may be in profound coma, cyanotic, bathed in a profuse cold sweat, pulse small and feeble, and very frequent, unmistakable evidences of impending dissolution; would you give that man your favorite remedy, acetanilid? After reaction is thoroughly established with high temperature, would you give him the remedy to reduce the temperature, and perhaps produce the same condition, from which your stimulants have raised him? We can hardly think any

Query—Diphtheritic Inflammation of Bowels.

Editor Medical Summary:

Did you ever have a case of diphtheritic inflammation of the bowels? If you have had any observations along that line and can give me some suggestions as to remedies and management, I will feel greatly indebted to you. Of all the troublesome, painful and obstinate affections that I have ever come in contact with, the above beats them all.

“MEDICUS.”

[We submit the above to our readers for a reply.—Ed.]

Best He Has Ever Seen.

Enclosed find \$2.00 for which advance my subscription to SUMMARY one year and send me your Call-Book and Ledger. I have used your Call-Book this year, and consider it the best book of the kind I have ever seen.

T. B. HOLMES, M. D.
Wadsworth, Neb.

tion is likewise usually two per cent. In mild cases it may sometimes be reduced to one per cent., and stronger solutions are rarely required. The same effect can be obtained with the two per cent. solution as with the stronger solutions if it is applied for a longer time.

It is equally important to know when not to use the silver solution. During the first stage of ophthalmia, when the lids are greatly swollen the conjunctiva congested and glistening and exuding a thin straw-colored serum, with sometimes a fibrinous deposit covering the conjunctiva, during this stage as Van Graefe showed, the nitrate of silver acts harmfully. If applied at all freely the conjunctiva becomes covered with a dense membrane which cannot be removed and which requires a number of days for its disappearance. But what is most serious is that this condition of the conjunctiva is frequently followed by corneal ulceration. It is necessary to curtail this state as much as possible and this can be done by means of cold applications; cloths which have been left lying on a block of ice are placed upon the eye in rapid succession and continuously, day and night.

As soon as the serous exudate becomes purulent we begin the use of the silver solution. But it is well to apply the solution very gently at first, brushing it over the conjunctiva but once or twice, for if applied vigorously even now, the false membrane may make its appearance. The solution is not to be dropped into the conjunctival sac as is frequently done. The lids are to be *thoroughly everted* and the solution penciled over the entire surface. Many surgeons neutralize the excess of the nitrate of silver solution with a little salt water. I have been in the habit of taking up most of the excess with a bit of absorbent cotton, and I believe the small quantity remaining is rather a benefit to that part of the conjunctiva which cannot be reached directly than a source of injury.

During the first few days, while there is still much swelling of the lids, it is necessary to continue the cold applications. It is most important to keep the eyes free from collections of pus by frequently separating the lids and washing out the eye with some mild solution, such as boracic acid solution.

The nitrate of silver is to be used once daily, and after the first

application or two it is to be penciled over the conjunctiva until a thin, milky layer is everywhere apparent; and it is well to follow this application with the cold cloths for half an hour or an hour to prevent too great reaction. This treatment is to be continued until the case is cured.

In those cases usually neglected in which a chronic ophthalmia is found and in which the conjunctiva presents enormously enlarged papillæ resembling the cock's comb, in these we are sometimes obliged to use stronger solutions, three or even four per cent., but with great care and careful protection of the cornea.

If I have gone into too minute details it is to impress their importance. Perhaps the following case will emphasize what I have said: I was called in consultation a few weeks ago to see a child which had shown the first sign of ophthalmia when two weeks old. The attending physician prescribed two solutions—one a boracic acid solution and the other a two per cent. solution of nitrate of silver. Through some misunderstanding the mother had instilled the nitrate of silver solution every hour or two for almost a week. When I saw the child at the end of this time there was a very moderate discharge, and on opening the lid I found a very white opacity taking up almost the entire lower half of the cornea and apparently superficial. I immediately suggested to the attending physician that this resembled much more a burn of the cornea than a specific ulcer. And later I obtained the statement given above from the mother. The opacity rapidly diminished in size and intensity, and in less than a month it had cleared to such an extent as to be visible only on close inspection.

That which is most to be feared in ophthalmia of the new-born is corneal ulceration. For when an ulcer has made its appearance it is impossible to foretell to what extent it will destroy the cornea and to what degree it will impair vision. I am sure, therefore, that the following case will be found interesting. In September, 1898, I was called in consultation with Dr. Hayden, who had been treating a child with severe ophthalmia of both eyes. In the left cornea there was a small peripheral ulcer about two or three mm. in diameter. Fearing that the ulcer would extend, I touched it carefully with a

sharpened point of a stick of lunar caustic. On the following day the ulcer was smaller, and in a few days it healed completely. I saw the child again at the end of two weeks. The ophthalmia had disappeared and there was not a trace of the ulcer.

In this case I feel reasonably sure that the radical treatment prevented extension of the ulcer and saved the vision.

HIGH AMPUTATION OF THE CERVIX AND VAGINAL SUTURE AS A PRELIMINARY TO ABDOMINAL HYSTERECTOMY, WITH THE REPORT OF A CASE.

By W. WAYNE BABCOCK, M. D., '93.

The supravaginal method of abdominal hysterectomy from its convenience and safety seems at present to be the preferable method of removing the uterus in most cases where there is no malignant or infectious disease. The smaller number of cases in which it is desirable to open the abdomen for the performance of total hysterectomy is usually operated upon by one of two methods. Either the uterus is removed entirely through the abdominal incision, curettage and cauterization being at times included in the preliminary preparation for vaginal asepsis; or, the broad ligaments having been ligated and divided by a celiotomy, the abdominal incision is closed and the uterine removal completed through the vaginal vault. The subjoined case has suggested the occasional usefulness of a somewhat modified reversal of this latter procedure.

The patient was a fleshy married woman, forty-seven years of age, and with a cancerous family history. Since the age of fourteen, she has suffered from occasional attacks of pain in the right hypochondriac region, that are associated with nausea, vomiting, and, at times, jaundice. More recently she has had a dull pain in the lower part of the back with a sensation of dragging weight in the pelvis; and during the past few months a procidentia has been noticed. Menstruation is not painful, has continued regular as to time, and has not been excessive in quantity.

An examination, with the patient recumbent, showed a narrow, elongated cervix protruding at the introitus vaginæ. Above, the cervix was continuous with a firm, resistant and globular tumor of about the size of a fetal head that occupied the pelvis and lower abdomen. No disease of the uterine adnexia could be made out. The family tendency to malignant disease, and the patient's urgent desire to be assured, as far as possible, against future malignant disease, made it seem desirable to extirpate the entire uterus as well as the fibroid tumor. This conclusion was strengthened by the fact that the cervix was elongated and in its prolapsed condition had been exposed for a considerable period to a greater or less degree of irritation, and by the experience of those operators who have noted an epitheliomatous development in the cervix left after a supravaginal hysterectomy.

The low-lying position of the tumor, with the attendant difficulties of satisfactory vaginal division, hemostasis, and suture through the thick abdominal walls, made it seem undesirable to do purely abdominal hysterectomy. On the other hand, a purely vaginal hysterectomy or a hysterectomy by the usual combined method was rendered inexpedient by the size of the tumor.

The following method was therefore adopted April 11, 1899. The patient having been etherized and the field of a vaginal operation aseptitized, the cervix was pulled down by a pair of tenaculum forceps and was encircled by an incision to the depth of the cellular plane. With continued traction upon the cervix, the adjacent tissues were carefully pushed off until the uterine vessels were exposed. These vessels were ligated with catgut and the cervix amputated at a high level. A provisional mattress suture of heavy silk was immediately introduced in the amputated face of the cervix in a manner to occlude both the oozing vessels and the divided cervical canal. Mattress sutures of catgut were then introduced to completely close the incision in the vaginal vault. Before these sutures were tied the cavity above the vagina was thoroughly irrigated and firmly packed with iodoform gauze. This packing served not only to limit any remaining oozing, but also tended to elevate the tumor in the pelvis,

to push the ureters, bladder and rectum from its lower portion, and to serve as a guide at a later stage of the operation. The sutures in the vagina having been tied, a supporting tampon of gauze was introduced into the vagina, the peritoneal cavity as yet not having been opened.

The second part of the operation was now begun by the conventional median incision through the abdominal walls. After liberating a few adhesions between the intestine and tumor, the ovarian and round ligament vessels were ligated on each side and the upper part of the broad ligaments divided. Connecting the broad ligament incisions by an incision across the face of the tumor, the bladder and broad ligaments were stripped down. Some hemorrhage occurred during the division from the left uterine artery and both uterine arteries were re-tied individually with fine silk. Guided by the gauze packing, the remaining structures were divided and the tumor (a fibromyoma with central necrosis), uterus, ovaries and gauze removed, the procedure being greatly facilitated by the fact that it was not necessary to interfere with the vaginal vault.

After suturing in turn the pelvic cellular tissues and the peritoneum over the vaginal stump with continuous sutures of fine catgut, the abdominal incision was closed, in layers, by buried sutures of chromicised and plain cumol catgut. Before the abdominal closure the gall-bladder was palpated for calculi but with a negative result. The convalescence was afebrile and associated with surprisingly little pain.

The procedure, in outline, consists of a preliminary high cervical amputation with the ligation of the uterine arteries, the constriction or coaptation of the face of the cervical stump and the cervical canal, and the approximation of the vaginal wound by sutures after the introduction of a packing of gauze or other material above the vagina. The peritoneum is not opened from below. The removal of the uterus through the abdomen is facilitated by: (1) The preliminary control of the uterine and vaginal vessels, permitting the complete arrest of the uterine circulation by ligature placed in the upper part of both broad ligaments. (2) The guide and support afforded by the gauze

packing below the stump of the cervix, that also, by pressing aside the ureters, bladder, etc., limits the danger of wounding these important structures. (3) The previous closure of the vagina, which not only renders it unnecessary to either incise or suture this organ through the abdominal incision, but also tends to limit the danger of peritoneal infection from this source.

Of course for the many cases of abdominal hysterectomy where there is no indication for the removal of the cervix, the method by supravaginal amputation is far preferable; while in many cases of uterine tumor in which the cervix is largely effaced or is displaced upward or backward, the procedure is hardly applicable. But in certain cases of large uteri, with benign or malignant tumors that are situated low in the pelvis, where there is an indication for the removal of the cervix the preliminary vaginal operation may diminish the chances of sepsis, facilitate the intra-abdominal work, afford a better technique and perhaps insure a better convalescence than the usual abdominal or combined panhysterectomy.

The indications for the removal of the cervix during a hysterectomy include: (1) All cases of malignant disease, or of tuberculosis of the uterus; (2) certain cases in which there is laceration, hyperplasia or inflammation of the cervix not to be relieved except by an extensive trachelorrhaphy or amputation; (3) certain cases in which the retention of the cervix is believed to predispose distinctly to a future malignant involvement. Of course there are cases of extensive malignant or infectious disease where the suture of the vagina may be unwise; but even here a temporary suture, to be removed and replaced by a drain after the abdominal closure, may prove of service.

3626 N. Broad Street.

MECHANISM OF AXIS-TRACTION FORCEPS.

BY DR. WILLIAM S. GARDNER, '85.

The consideration of the mechanism of the axis-traction forceps includes the following points:

1. The pelvic curve of the instrument should be made to correspond as nearly as possible with the curve of the unyielding portion of the pelvic canal.

2. The cephalic curve should be so constructed as to give a firm grasp of the head of the child, without too much compression.

3. The traction rod and handle should be so placed that traction will be made as nearly as possible in the direction of the pelvic canal.

4. The instrument should be made of material that can be sterilized by heat without injury.

The determination of the direct pelvic curve has been one of the most difficult questions in the whole history of the construction of forceps. The original forceps had no pelvic curve, and Leveret first added this improvement. Since his time the pelvic curve has been many times modified. Some inventors have tried to make it conform to what they conceived to be the true pelvic axis; others have modified it empirically without any basis from which to calculate what it should be.

The question resolves itself into two sections: 1. What is the true course of the head of the child through the unyielding portion of the pelvic canal? 2. An arc of what circle will approach most nearly to the true course of the head?

In estimating pelvic axes it is generally conceded that the axis of the superior strait is a perpendicular to a line running from the promontory of the sacrum to the upper border of the symphysis pubis. The axis of the inferior strait is not so easily determined. Most authors say that it is a perpendicular to a line running from the tip of the coccyx to the under border of the symphysis. There are two fallacies in this, the usual statement. The first fallacy is that the tip of the coccyx is not a fixed bony point. In fact, it is as subject to variations in position from pressure as any of the soft parts. The second fallacy

is that the head does not emerge directly under the symphysis, but a considerable distance below it. So, as neither end of this antero-posterior diameter is correct, it is useless as a basis of measurements.

To begin again, then, we find, passing down the posterior wall, that the tip of the sacrum is the last fixed bony point. This, then, and not the movable tip of the coccyx, should be considered the inferior boundary posteriorly of the bony pelvic canal.

The next point that it is necessary to fix is the point below which the head must pass before it can emerge under the arch of the pubis. To find this point it is necessary to bear in mind the well-known fact

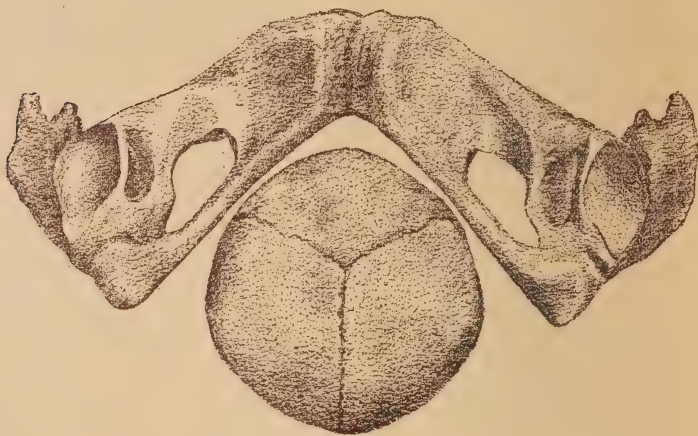


FIG. 1.

that the descending rami of the pubes diverge from each other at an angle of 90° , and that a line drawn across the occiput of the child's head from one parietal eminence to the other describes, on the average, the arc of a circle whose diameter is three and one-half inches.

This being the case, the head can fill up only a little more completely this angle than can an arc of a circle fill up a right angle; or, in other words, a round ball never completely fills up a square hole. If the rami formed a complete right angle, the uppermost curvature of the sphere would correspond to a point three-quarters of an inch from the vertex of the angle, and a tangent to the circle of the head

at this point limited at either end by the rami would be about one and one-half inches long. In the pelvis this line running horizontally from one ramus to the other is one and one-half inches long; but on account of the vertex of the angle being somewhat filled up, the head approaches at the nearest point to within about half an inch of the lower border of the symphysis, and this is the point below which the head must come before it can curve forward. In other words, the anterior pelvic wall below which the head must pass is the depth of

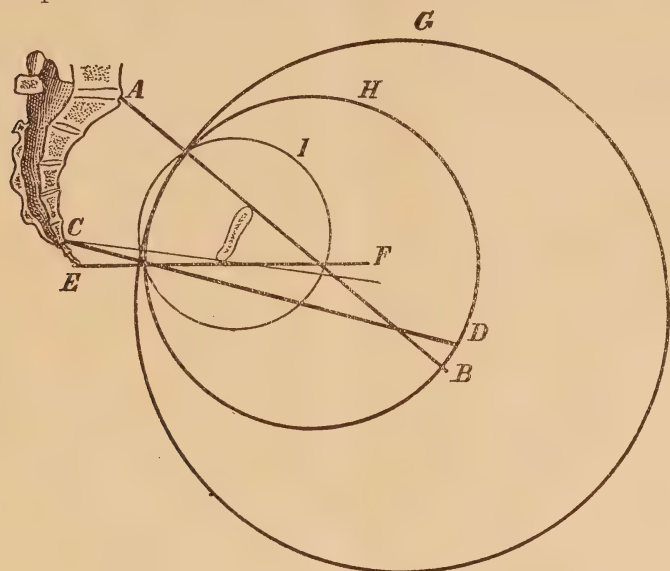


FIG. 2.

the symphysis plus half an inch contributed by the rami of the pubic bones.

Fig. 1 represents the head emerging from under the arch of the pubis. This drawing was made from a photograph, and shows that the head does not come immediately under the symphysis, but a considerable distance below it.

It is perfectly well known that the axis of the pelvic canal cannot be accurately represented by the arc of any one circle; but from a mechanical standpoint, for the purpose of selecting the best possible

curve for the forceps, we are compelled to select an arc of that circle which most nearly represents the direction of the axis of the average pelvic canal.

A number of attempts have been made to determine this arc which most nearly approaches the axis of the pelvic canal.

The circle of Carus is the result of such an attempt, but its incorrectness has long been recognized. Another similar attempt was made by taking the point at which two lines, one running from the promontory of the sacrum through the upper border of the symphysis, and the other from the tip of the coccyx through the lower border of the symphysis, would meet, and, using this point of juncture as a center, describing a circle whose radius would be the distance from this point to the middle of the superior strait. This radius in the average pelvis is about four and one-quarter inches. As has been shown above, this diagram is based upon an incorrect conception of the outlet of the pelvis. And this misconception places the base line representing the plane of the outlet of the pelvis in an incorrect position. These points can be more clearly shown by reference to the figures.

Fig. 2 represents the method of obtaining the arc of a circle that most nearly approaches the pelvic axis. The line *A B* represents the plane of the superior strait and its continuation. The line *C D* represents the true plane of the inferior strait; that is, a line from the tip of the sacrum, the last fixed point behind, through the point under the symphysis below which the head must pass. The line *E F* represents the incorrect but usually represented plane of the inferior strait. The smallest circle, *I*, represents the circle of Carus, the center of which is the symphysis. The second circle, *H*, is a circle whose radius is half the diameter of the superior strait plus the distance from the upper border of the symphysis to the point of junction of the lines *A B* and *E F*.

The third circle is one whose radius is half the anteroposterior diameter of the superior strait plus the distance from the upper border of the symphysis to the junction of the lines *A B* and *C D*. This diagram was drawn from the average measurements of the normal female

pelves used in teaching at the College of Physicians and Surgeons of Baltimore and at the University of Maryland. I was kindly allowed the privilege of measuring these latter through Prof. J. Edwin Michael. The average measurements were as follows: The diameter of the superior strait, four and three-eighths inches; from the tip of the sacrum to the lower border of the symphysis, four and one-quarter inches; the length of the sacrum, three and fifteen-sixteenths inches; the depth of the symphysis, one and five-eighths inches; the distance from the upper border of the symphysis to a point which is at the junction of a perpendicular dropped from the symphysis and a line connecting the points on the rami of the pubes at which they have

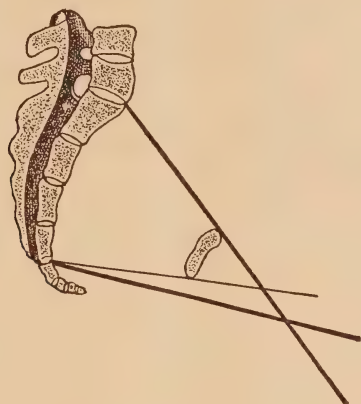


FIG. 3.

separated to a distance of one and one-half inches, is two and one-twelfth inches. It is found that the distance from the middle of the anteroposterior diameter of the superior strait to the junction of the lines *A B* and *C D* is seven inches, and the arc of a circle whose radius is seven inches will strike both the planes of the inlet and outlet of the bony pelvis at right angles, and will follow the direction of the canal through the cavity of the pelvis with as much accuracy as an arc of a circle can do. From this it can be readily understood that the pelvic curve of forceps to most nearly correspond with the axis of the bony canal of the average pelvis must be an arc of a circle whose radius is seven inches.

Fig. 3 shows a pelvis with normal anteroposterior diameter, but with an unusually long sacrum, and with symphysis not so deep as the average—making the curve of the pelvic canal the arc of a smaller circle than the average.

Fig. 4 shows a pelvis with normal anteroposterior diameter, but the sacrum is very short and the symphysis deep—making the curve of the pelvic canal the arc of a much greater circle than the average.

These two figures are given to impress the fact that, so far as pelvic curves are concerned, we can never do more than approximate the truth. It is evident that we cannot have a new instrument for each



FIG. 4.

patient, and the best we can do is to use *that* instrument which is most nearly correct for the largest number.

This brings us to the consideration of the cephalic curve. The *ideal* cephalic curve is one that will grasp the head firmly and at the same time will not compress the head.

The biparietal diameter is the diameter of the head most frequently within the grasp of the forceps. From an average of seventy-five heads measured immediately after birth I have found that the biparietal diameter averages three and one-half inches. And we must bear in mind that the heads that must be delivered by forceps are above rather than below the average size. Then, to secure the advantage of the greatest amount of available space, the head must not be forced by the forceps out of shape to satisfy the peculiar ideas of the

operator, but must be allowed to mould itself as much as it will to fit the irregularities of the pelvis.

Many of the forceps now in use are made with a cephalic curve so slight that it is necessary to approach the blades very closely in order to grasp the head firmly and prevent slipping. In this way the head of the child is compressed. Compression of the head does not diminish its size, but decreases one diameter while it increases the other diameters. So that when the head is grasped by slightly curved blades and compression used, not only is danger of injuring the head incurred, but the labor is positively obstructed by decreasing that diameter of the head which occupies the greater or transverse diameter of the pelvis, and increasing the diameter of the head which occupies the narrower anteroposterior diameter of the pelvis. To meet these conditions I have constructed a cephalic curve which differs considerably from any now in use. The whole length of the blades in a straight line that is affected by the cephalic curve is six and one-half inches. When the blades are closed they approach at the tips to within three-quarters of an inch of each other. At the widest part, which is three inches from the points, the blades are three and one-quarter inches apart. At the point where the cephalic curve proper stops, the blades are one and one-half inches apart. The curve from this point to the widest part of the blades is the arc of a circle whose radius is four and one-eighth inches. The remainder of the curve is the arc of a circle whose radius is seven inches.

Another point which improves the grasping power of forceps, is to have the lock as far from the point of the blades as it can be placed without so much increasing the length of the forceps as to make them troublesome to carry about. When the distance from the point of the blades to the lock is short, the blades diverge rapidly when they are opened and the grasping power is soon lost. On the other hand, when the blades are long the grasping portion of the blades can be separated very widely without losing their power to retain a globular body between them. By this increased cephalic curve, and the long blades, I have endeavored to solve the question of how to obtain a firm grasp of the head without compression.

After the pelvic curve has been definitely fixed it is comparatively easy to adjust the traction rods.

The traction handle should be so placed that the force will be exerted along that chord of the arc of the pelvic curve of the instrument extending from the point of greatest resistance to the point of attachment of the rods. The point of greatest resistance will be that portion of the blades which includes the greatest diameter of the head.

If the handle is attached to the perpendicular portion of the traction rod so that its center falls on any point on an extension of this line,

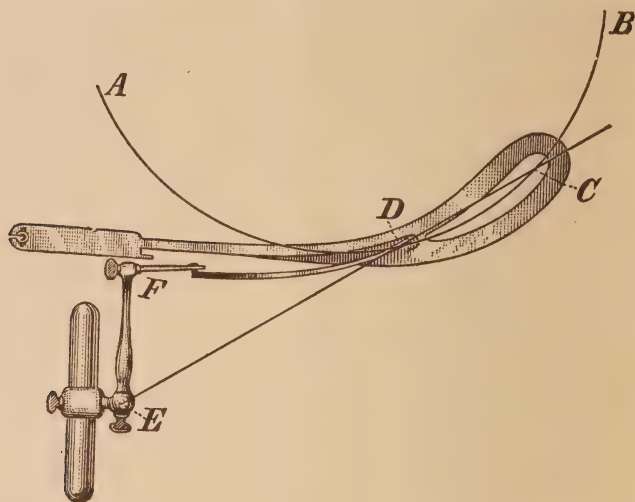


FIG. 5.

axis traction is obtained. If the center of the handle is either above or below this line, we may have a traction-rod forceps, but not an axis-traction forceps.

There should be a joint at the angle of the traction rod which will allow the forceps to rotate upon its own axis without changing materially the point at which the force is exerted. This joint allows rotation of the head as it descends, and in occiput posterior positions it will allow the complete rotation of the occiput to the front. This apparently very simple device is found in practice to be of very great importance.

In Fig. 5, the arc AB is an arc of a circle whose radius is seven inches, which, as has been shown above, is the arc which most nearly corresponds to the direction taken by the head of the child in its progress through the practically immovable portion of the average pelvic canal. The line CD is the chord of that arc from the point of estimated greatest resistance to the insertion of the traction rods. DE is an extension of this line until it falls upon the point at which the force is applied. F is the joint at the angle of the traction rod.

There is no instrument that it is more essential to keep as nearly as possible up to the standard of perfect cleanliness than the forceps. For this reason it should be made without fixed joints, so that each piece can be cleaned separately. The blades, handles, and traction rods should be made all of the same material, or at least of such material as can be sterilized by either dry or moist heat without injury.

I have had a pair of forceps made upon the lines given above. Since then I have used them in all high forceps operations and have not been disappointed in them.

They have the following points in their favor:

1. They give real axis traction.
2. They do not compress the head.
3. They do not slip off.
4. They allow free internal rotation of the head.
5. They can be kept perfectly clean.

1012 McCulloh Street.

BALTIMORE AS A CENTER OF POST-GRADUATE MEDICAL STUDY.

BY DR. T. J. MURPHY, 99.

Baltimore as a center of post-graduate medical study is rapidly forging to the front. Years ago, physicians anxious to keep abreast of the times in medical studies sought the colleges in the larger cities, principally New York. Now, however, many of these look elsewhere for such advantages with the result that the College of Physi-

cians and Surgeons in this city has now a number of physicians taking a post-graduate course in medicine.

No one who recognizes and appreciates the giant strides being made in medical research will dispute the advantage which accrues from taking frequently a post-graduate course. New ideas in the treatment of certain diseases are almost constantly being advanced, and after being tried and found to possess merit are put into use by the progressive practitioner. Advanced methods of performing surgical operations are presented to our astonished gaze until we wonder not infrequently when will the science of medicine have attained that perfection which will admit of no further improvement! I do not believe that time will ever come, for I consider that investigation will go on as long as the world endures, and if the physician is to keep up he must be familiar with the results of these labors. As an instance, I might mention the microscope. Twenty years ago this instrument was little used in medicine. Now, it is regarded as indispensable and an essential factor to every student of medicine.

Recognizing the imperative need of such study, the question confronting the physician anxious to avail himself of it is to find the college where he can best enjoy the needed facilities for requiring the knowledge which he desires. The fame of many colleges in New York having spread throughout the country, post-graduate students have in the past gone to that city in large numbers with the result that the medical colleges there are taxed to their utmost capacity. In many of them, as a matter of fact, there are more post-graduate students than there are clinics. This condition, it can readily be seen, operates to the disadvantage of the post-graduate student. Again it is known that in some of the hospitals connected with the New York colleges the most interesting cases are not examined and discussed in a general clinic but are withheld by the resident physicians for their own especial diagnosis and study. Students in these institutions are thus deprived of the very knowledge which they seek in going there.

In this respect, Baltimore occupies an unique position. Its medical colleges have a standing and a reputation as high as any in this

country and so far have not been overrun with post-graduate students, with the result that all who are here taking such a course of study are enjoying exceptional advantages. Of medical colleges in the Monumental City, there is not one which offers better facilities or greater advantages to the post-graduate student than does the College of Physicians and Surgeons. In the free dispensary connected with this institution there are treated daily a large number of cases, some of which prove to be most interesting and instructive. Besides this, the post-graduate student has the advantages which result from the daily observation of about 200 cases in the City Hospital which adjoins the college and is practically a part of it. A still further advantage is given in the Maternite Hospital, where about twenty cases are under observation daily. Added to these unusual advantages is the uniform and unfailing courtesy with which the post-graduate student is treated by the members of the faculty and resident physicians.

There are now a number of post-graduate medical students at the College of Physicians and Surgeons, but as they are yet few in number they enjoy advantages which they could not obtain elsewhere. Unlike the post-graduate students in some of the New York medical colleges, they are not shown some cases, but enjoy the facility of examining every case. More knowledge is thus acquired here in the same space of time by the post-graduate student than he would obtain in the colleges in the great metropolis of the north. It is needless for me to dwell upon the unsurpassed advantages possessed by Baltimore as a place of residence. Board of the best kind can be obtained here at a moderate rate. It is a beautiful city, rich in architecture and with a wealth of rural scenery which can be enjoyed after a ride on the electric cars through the city famed for its beautiful women, numerous monuments and gastronomic productions.

In summing up, I feel safe in predicting that Baltimore is going forward in medical study and that physicians anxious to take a post-graduate course in looking over the field in the future will take cognizance of its superior advantages and come here to obtain the knowledge which they must acquire in order to keep in the front rank of

their profession. Progress is the order of the day and no man can afford to remain at a standstill. He must go forward or retrograde. Pushing, studious young men will, so to speak, push him to the wall. Baltimore medical colleges, and especially the College of Physicians and Surgeons, must reap the advantage.

THE TREATMENT OF SYPHILIS BY THE GENERAL PRACTITIONER.

By DR. HARVEY P. JACK, '91.

Notwithstanding the fact that syphilis has been known and described for hundreds of years, it has been reserved for the science of the past decade to place this disease in its definite category and to give us the most extended and enlightened views as to its pathology, diagnosis, prognosis and treatment.

It is indeed surprising in glancing over the literature of the past twenty years to know how much of the behavior of the disease has been shrouded in mystery. It has been in the past looked upon as the dread terror, both by laity and profession, and indeed its behavior, if unchecked and untreated, entitles it justly to much of the dread it has inspired.

Its victims have been, and I am sorry to say, still are, by a large number of the profession, looked upon as vermin who might better be dead than alive, and I believe it is to this prejudiced and oftentimes ignorant view of these cases that this disease is frequently so loosely treated.

It is asserted in some of the text-books not twenty years old that almost all cases of syphilis sooner or later reach the so-called tertiary stage. This view is often still held and quoted in spite of the fact that we know now from the statistics of Fournier, Mauriac, Hyde, Kaposi, Keyes, Haslund and White that 90 per cent. never have gummatous syphilis, including the well treated, the poorly treated, and those not treated at all, and 74 per cent. of those who do reach this stage are either poorly treated or not at all. Fournier says almost

all who reach this stage, so-called, are the untreated or poorly treated cases. I append his statistics which are based on 1703 cases of gummatous syphilis:

No treatment	217 cases.
Treated for less than one year	1162 “
Treated from one to two years.....	265 “
Treated for more than two years.....	53 “
Treated for more than three year.....	6 “

At a glance we see that only 59 cases suffered from gummatous syphilis in spite of conscientious treatment.

These statistics teach us, further corroborated as they are by the experience of every syphilographer of eminence, three things:

1. The continued use of mercury acts not merely upon the manifestations of the disease, but directly upon the germ of syphilis.
2. That in well-treated cases, gummatous syphilis is a complication and not a scheduled time-station in the course of syphilis.
3. That well-treated syphilis is a benign disease capable of absolute cure.

Regarding the first proposition, there is practically no dispute to-day among the most eminent observers. Keyes, Hyde, Haslund, Vajda, Drysdale, White, Mauriac, all corroborate strongly this fact. And apart from above statistics, the power of mercury over even latent syphilis is shown by two facts with which we all are, or should be, very familiar, viz.:

The very mild character of the succeeding symptoms in persons who have taken mercury from the appearance of the chancre and the effect even in latent syphilis on the fœtus, the father only being syphilitic, the mother constantly subject to abortion. Treat the syphilis of father with mercury and the abortions stop and a healthy child may even be carried to term.

The anti-mercurial school may fortunately be said to have passed out of existence, and over its grave is rapidly being erected a monument of sensible observation and fact regarding the use of the drug in syphilis that will stand firm for generations.

Regarding the second proposition: If we treat 100 cases of scarlet fever and ten of them develop a perforating otitis media, we do not call it a stage of scarlet fever to be naturally reached in the course of the disease, but a complication due, no doubt, many times as is gummatous syphilis, to poor early treatment.

The classification of the eminent Baltimorean, Ricord, of Paris, is undergoing a revision if not a complete change at the hands of our best syphilographers. It is no longer followed in Paris, the city of its birth, for the reason that it constantly befuddles the mind of the profession. It is surprising how deep-rooted is the idea that all cases of syphilis must sooner or later have gummatous syphilis.

A man with a large practice, in spite of all the above facts recently proven, remarked to me not long ago that he did not believe syphilis was ever curable. In view of the above truths, this is ignorance. Such a man, believing he cannot effect the cure of syphilis, will not, for he can see no end and will have no ideals, no logical basis for beginning treatment.

In fact, my excuse for the presentation of this paper has been the occurrence in my practice of the circumstances of several cases of severe syphilis, who have been in the hands of some of my associates, supposedly able men. Not one of these cases knew the disease from which he was a sufferer except in the fantastic idea of the laity, although they were all occasionally taking mercury, showing the diagnosis had been correct. They were to show up some time if they had any symptoms. In view of the above demonstrated facts, this is nothing less than criminal ignorance, and I would urge upon us all as general practitioners, who treat in the aggregate most cases of syphilis, the necessity of obtaining a correct, up-to-date conception of the behavior of this disease, and of the importance of early, long-continued and skilful treatment.

Says Osler: "In view of the fact that syphilis is one of the most amenable diseases to treatment, the occurrence of so many later cases of syphilis as do occur is lamentable."

The profession, however, is only half at fault, the patient often being neglectful when he finds his disease does not amount to as much

as he thought at first; but much may be done by the physician urgently insisting upon the fact that syphilis is not cured in a few months, but requires at least two and one-half years of constant supervision.

I would urge that the profession learn and do its full duty in this respect, as the sin of omission is greater than the sin of commission. When a case of syphilis confronts you, do not make hysterical and overdrawn statements to your patient, but lay the case before him squarely as it is, its dangers and its results, and finally show him that the severity of his disease is dependent upon himself to a very great extent, to his regularity, actions, and habits, and, in the majority of cases, you will find the patient constantly ready to co-operate with you in his cure. Especially will this be true if the patient is intelligent. Very many cases of syphilis (Keyes, Horwitz), go through their course of treatment at the hands of a competent specialist and come out of the ordeal feeling and being better than before they contracted the disease. There is no reason why this should not be true to a greater extent than it is in general practice. What is true of the effect of treatment of gummatous syphilis is true also according to our most competent observers of post-syphilitic disease, although no statistics are yet forthcoming in proof of this latter statement, it is believed by all, and, in fact, locomotor ataxia is included by Fournier as gummatous syphilis in his statistics.

All this should prove to us the vital importance of early, prolonged and skilful treatment, and should remind us of the sin of omission we are committing if we fail to impress upon our patients the facts about syphilis and educate them up to the point necessary to maintain their co-operation for three years in our efforts for their cure.

Regarding the third statement, I think it will be admitted without further argument, as it is a matter of fact proven by the previous statements, demonstrations and statistics.

In taking up the treatment of syphilis in detail, I shall adopt the classification of Prof. Hyde, of Chicago, for the reason that it is exact and tends to clarify our ideas of syphilis, and forms a better basis for the study of the various methods of treatment.

Syphilis has for years been divided into three stages—primary, secondary and tertiary—conveying the idea that a man, if neglected, should, by the time-schedule, pass through a primary to be followed by a secondary stage of syphilis.

“During this second stage,” says Prof. Hyde, “he should, if untreated, exhibit crop after crop of different syphiliodermata, and as these progress toward malignancy, he should eventually reach a tertiary stage of the disease.” Says Hyde: “This misconception of syphilis will rule the professional world for years to come and, as a consequence, the manifestations of syphilis will long be regarded as occurring with all the regularity of the vesicles and pustules of variola.” “But the fact is, there never was such a syphilis and probably never will be.”

We have all, I am sure, in our reading, noticed the apparent efforts to explain the glaring inconsistencies of this classification of Ricord of primary, secondary and tertiary, in which a man exhibits a gumma due in the third year of the disease in the first year, writers have been obliged to invent the term precocious syphilis, or where a man exhibits any other symptoms not on schedule time.

“As a matter of fact,” says Hyde, “most malignant syphilitic symptoms are such soon after infection. Many syphilitic subjects never exhibit any single symptoms of so-called tertian; in other words, never reach this stage on schedule time or any other time.”

Prof. Hyde considers syphilis as other diseases, reacting differently upon different individuals; as a matter of fact it does; and Horwitz agrees with him in its tendency to give early indications of its malignancy in a given case.

This seems to me to give us a much clearer conception of syphilis as it really is, and relieves us of the constant and futile attempt to reconcile facts and occurrences in the course of the disease with a time-card syphilis, which ought to be such because we have been taught that it is such.

To be continued in the next number of the Journal.

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THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

THE TEACHING OF PRACTICAL MEDICINE.

THE extension of the course of study in medical colleges to four years entails radical changes in the methods of teaching. A glance at the schedules issued by many medical colleges shows only too plainly that the necessity for these changes has not been recognized, and the present four years' work is too often very little more than a repetition of the old two years' course. In the schedule prepared for the coming year at the College, an attempt has been made to utilize the time to the best possible advantage. The most radical changes have been made in the work of the fourth year class. In this year each man gets twenty-two hours per week of clinical work. Nearly all of this work is done individually or in small sections. The controlling idea is that a student at the end of the course shall have not only a book knowledge of disease and its treatment, but that he shall be able to recognize diseases when he comes in contact with them and be able to treat them intelligently; that by close, constant personal contact with patients, the student shall be converted into the practical physician.

THE new College building spoken of in the last issue of the JOURNAL is practically completed, and, by the time this issue reaches

the Alumni, will be in daily use. It is hard to realize without seeing it, what a tremendous improvement this building is over the ordinary medical college building. Three amphitheaters, five laboratories, three class-rooms and a large library and study room, give ample opportunity for each class and each man to work to the best possible advantage. No one will be more surprised and pleased with the change than the returning student.

The operating tables and other surgical appliances for the new operating room in the City Hospital have been furnished by the Chas. Willms Co.

Personal Notes.

DR. JOHN WAKEFIELD WICKLIFFE, '88, is one of the physicians at the Manhattan State Hospital, New York.

DR. B. F. CHURCH, '88, is surgeon-in-charge of the Los Angeles Eye, Ear, Nose and Throat Hospital, Los Angeles, Cal.

DR. M. E. SILVER, '97, has been elected Demonstrator of Anatomy in the Sioux City Medical College at Sioux City, Iowa.

DR. M. J. MORRISY, '97, after doing a term of post-graduate work at the Boston City Hospital, has located at Unionville, Conn.

DR. J. C. MADARA, '98, who was last year one of the residents at the City Hospital, is now practicing at Ridgely, Caroline County, Md.

DR. CHAS. W. VOGEL, '95, was appointed assistant surgeon in the Marine Hospital service July 25, and assigned to the port of Boston.

DR. H. V. CASSIDAY, '93, has removed from Salina, Kan., to Mt. Pleasant, Utah. We hope he will do as well there as Dr. Sam. Allen did.

DR. M. H. C. DEVILBISS, '77, of Chambersburg, Pa., was in Baltimore recently. He is physician to the jail, on the staff of the Children's Aid Society Hospital, and examiner for several life insurance companies.

DR. M. L. UNRUH, '81, died at Germantown, Pa., March 16, 1899. He was the only son of the Rev. John N. Unruh, and was born in Freesburg, N. J., in 1859. He had been practicing in Philadelphia for several years.

DR. J. TRIGG WADE, '84, died September 2, at Arlington, Neb. He was surgeon to the Elkhorn Branch of the Chicago and Northwestern Railway Company for several years. He was a brother of Dr. J. Percy Wade, Superintendent of Spring Grove Asylum.

Since the last college session three new professors have been elected to membership in the faculty. For the information of the alumni the following brief sketches are published:

DR. WILLIAM F. LOCKWOOD, Professor of Materia Medica, Therapeutics and Clinical Medicine, was born in Culpeper County, Va., but was reared in Baltimore County, Md., where for many years his father was Rector of St. Thomas' Church, Garrison Forest. He spent one year in the academic department of the University of Virginia, and then taught school for three years. He took his degree in medicine from the University of Virginia in 1875, and after one year as Resident Physician to St. Joseph's Hospital, Baltimore, he began to practice in the city, and was appointed one of the visiting staff to the old Baltimore General Dispensary, then located on Liberty Street. For a short time he was a Demonstrator of Anatomy in the Washington University, and after that school of medicine was absorbed by the College of Physicians and Surgeons, he continued as Demonstrator of Anatomy for three years.

For the past fifteen years his attention has been given to looking after a general practice, a Dispensary for Children and the duties of Visiting Physician to St. Joseph's and St. Agnes' Hospitals.

For nearly seven years he was a member and, the greater part of that time, secretary of the State Board of Medical Examiners.

DR. EDWARD N. BRUSH, professor of psychiatry, was born on his grandfather's farm Glenwood, about twenty miles from Buffalo, N. Y. Until 1878 he lived in Buffalo, where he was educated and where he took his degree in medicine in 1874 at the Medical Department of the University of Buffalo. From 1874 to 1878 he practiced medicine in Buffalo, paying more particular attention to surgery and acting as assistant to Prof. Julius F. Miner, surgeon, and to the late Prof. James P. White, gynecologist. He lectured on Electro-Therapeutics in the Medical Department of the University of Buffalo from 1876 to 1879; was editor of the Buffalo Medical Journal, 1874 to 1879; Assistant Physician New York State Lunatic Asylum 1878 to 1884; Associate Editor of American Journal of Insanity, 1878 to 1884, and since 1897 has been one of the editors of that journal; Senior Assistant Physician Pennsylvania Hospital for Insane (Kirkbrides), Philadelphia, 1884 to 1891; since 1891 Superintendent and Physician-in-Chief at Sheppard and Enoch Pratt Hospital.

For Wood's Reference Hand-book of Medical Sciences he contributed the articles on "Epileptic Insanity," on "Hypochondriacal Insanity" and on "Idiotic Imbecility and Cretinism."

For Keating's Cyclopeda of Diseases of Children he wrote the article on "Idiocy and Imbecility." For Hare's System of Therapeutics the article on "Hospital Treatment of the Insane."

From the very beginning of his career Dr. Brush has been a liberal contributor to current medical literature. When he was a budding surgeon and gynecologist, he wrote on these subjects; but as he has for many years devoted his entire time to mental diseases, the great bulk of his contributions have been subjects directly in line with his work. These papers are so numerous that lack of space prevents the publishing of even the titles of them.

DR. I. R. TRIMBLE, Professor of Anatomy, was born at "Wye House," the property of his grandfather, Col. Edward Lloyd, in Talbot County, Md., October 10, 1860. He lived at his home, "Wye Heights," Talbot County, until 1877, when he went to the Shenandoah Valley Academy at Winchester, Va., where he spent three years. After leaving there he spent three years at the Johns Hopkins University working in the courses preliminary to the study of medicine. He took his degree in medicine from the University of Maryland in 1884. The following year was spent as assistant resident physician to the Hospital of the University of Maryland. In 1890 he was elected surgeon to the Baltimore and Ohio Railroad, and now ranks next to the surgeon-in-chief. He was assistant surgeon of the Fifth Maryland Regiment from 1889 to 1899. During the construction of the Belt Line Tunnel, which is the longest soft-ground tunnel in the United States, he was surgeon-in-charge of the workmen. There were over twenty-five hundred persons injured during its construction.

He has been Lecturer on Clinical Surgery at the University of Maryland for five years.

In 1890 he was elected Professor of Anatomy and Clinical Surgery at the Woman's Medical College of Baltimore.

He is now chief surgeon to the United Railway and Electric Company of Baltimore City. This company owns every electric car line in and about Baltimore.

DR. W. WAYNE BABCOCK, '93, writes:—

Was much interested in Dr. Beck's report of Retro-Calcaneal Bursitis in your July number. In '96, while medical director of a gymnasium, I had an acute attack that I attributed (1) to the excessive gymnastic exercise and (2) the frequent cold shower-baths. The two features of treatment that proved in my own case of greatest value were not mentioned by Dr. Beck. These were (1) a very thick heel pad to remove the pressure of tendon from the bursa by raising the heel, and (2) the direct injection, by hypodermic needle, of a sterile 2 per cent. solution of carbolic acid. The latter was especially useful in relieving the pain and cutting short the disease, the duration being about three weeks.

W. W. B.

No. CAMBRIDGE, MASS., July 21, 1899.

DR. W. S. GARDNER.

Dear Doctor.—Please enclosed find \$1 for JOURNAL. I hope you have not forgotten me altogether, though you have not seen me since '92, when I graduated. I was in your "quiz," which, I suppose, accounts for my success.

I have been here in Cambridge since graduating, and have done so well that I was able to go to Europe for 6½ months last year, after beginning practice in debt.

I was sorry and shocked to hear of Dr. Rohé's death.

I and another '92 man, Dr. D. T. O'Keefe, of Jamaica Plains, Boston, have been threatening to go down to Baltimore for a long time, and will go soon.

Please give my best wishes to the professors and accept them for yourself.

Very truly,

C. J. WALSH, '92.

PITTSBURGH, PA., July 21, 1899.

DR. WM. S. GARDNER, 1012 McCulloh Street, Baltimore, Md.

Dear Doctor.—Please find my subscription for the JOURNAL. I have been fortunate enough to build up a lucrative business in this busy city of ours. We have several P. and S. men here and all are doing well. You have my best wishes for success.

Yours fraternally,

FRANK J. PHILLIPS, '89.

PROVO, UTAH, July 20, 1899.

DR. WILLIAM S. GARDNER, Baltimore, Md.

Dear Doctor.—Inclosed find \$2 P. O. money order, for which please credit me on the ALUMNI JOURNAL up to April, 1900.

Three numbers only have reached me. I have Nos. 1 and 3 of Vol. I, and No. 1 of Vol. II. Kindly send me Nos. 2 and 4 of Vol. I, and No. 2 of Vol. II, and the rest as they are issued. I must have them; can't do without them. The JOURNAL is a comfort; a

consolation to me since being separated from so many good, true men and friends.

Now, Doctor, please attend to this little matter for me.

Have a nice practice for a youngster, and gaining every day. Was appointed County Physician in January. Have had a nice lot of surgery and a wide variety. Almost everything, from ingrowing toenail to laparotomy and hip-joint amputation.

Have done more surgery than any man in Utah County during past ten months with possible exception of Allen, and during past six months have run him a close race. Last but one case, old man, 67, with empyema of five months' standing. Operated upon him and he died three months later of acute dysentery.

Did a perineorrhaphy. Complete laceration through anal sphincter. Perfect result. Had one hip-joint amputation. Recovery. One radical hernia. Good result.

Recently operated on appendicitis. Very interesting case. Abscess in both iliac fossæ. Recovered and doing finely. Allen and I removed ovary last week. Doing well. Allen's case. Recently did amputation of leg. Lower third. Doing well. Also had empyema case recently. Operated, and patient getting well. Cured uterus two weeks ago. Removed urethral calculus recently. Have never regretted going to old Baltimore and the P. and S. Am proud of my school and all of you.

With kindest regards to my friends and professors, and best wishes for yourself, I am,

Very truly,

GEO. E. ROBISON, '98.

P. S.—Have you got a baby yet?

(Yes; boy. Born July 15.—W. S. G.)

DR. HARRY FRIEDENWALD, Baltimore, Md.

My Dear Doctor.—I wish to report to the JOURNAL the progress of several of our Alumni in Central Pennsylvania.

Dr. C. E. L. Keene, '91, has been located in Harrisburg since graduation; is married; has one child. The Doctor is the fortunate

possessor of a genial disposition, is a hard worker, and, consequently, has a very lucrative practice.

Dr. T. V. Williams, '92, has been practicing in Nanticoke since '96; prior to that at Glen Lyon. Dr. Williams is making a specialty of electro-therapeutics. His brother, R. J. Williams, is located at Plymouth, and is a very busy general practitioner.

Dr. D. W. Kingsbury has a flourishing practice at Nanticoke.

Dr. H. M. Werner, '92, located in same city. The Doctor completed a post-graduate course at Johns Hopkins in 1898, and is a well-known man in his section.

Dr. Wm. Lewis, '92, is in South Wilkesbarre.

Dr. Ed. Davies is doing well at Glen Lyon.

Dr. R. S. Schwertzer, '81, is located at Adamstown. The Doctor has a large practice, is examiner for several life insurance companies, a member of Town Council and Lancaster County Medical Society. He desires to renew acquaintanceship with some member of '81.

Dr. John J. Snyder is Assistant Surgeon, U. S. N., on receiving-ship Nataale, Boston Navy Yard.

Your humble servant graduated in '96, and after passing State examination, opened an office in Harrisburg, and am still at the same old stand. I am a member of the local society, and am happy to say have a prosperous and growing practice. I was married last year and find the new state very agreeable, and would advise all other young M. D.'s to do likewise.

Respectfully,

CHAS. S. REBUCK, M. D., '96.

202 N. 6th Street, Harrisburg, Pa.

Sept. 27, 1899.

NO OTHER SERUM

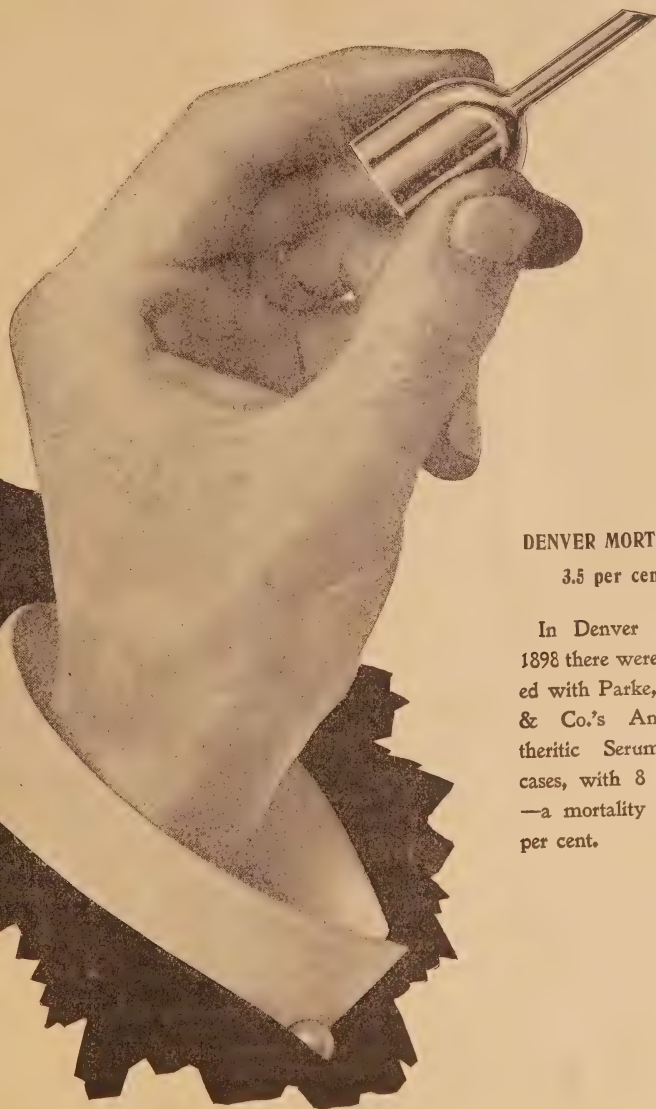
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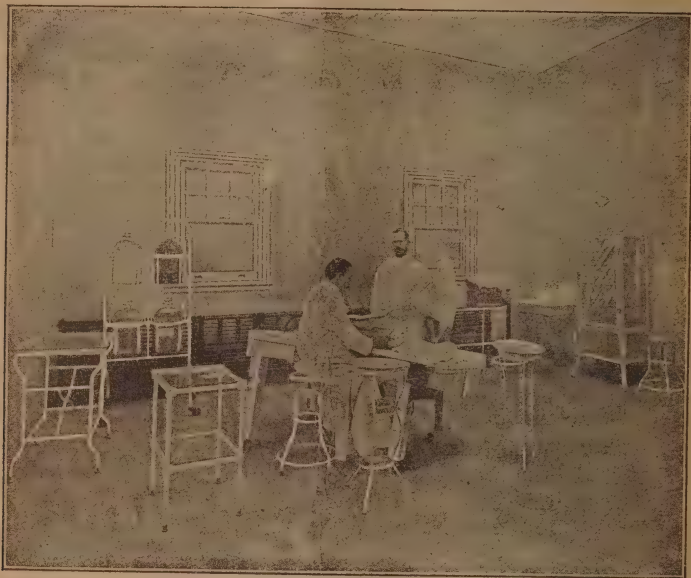
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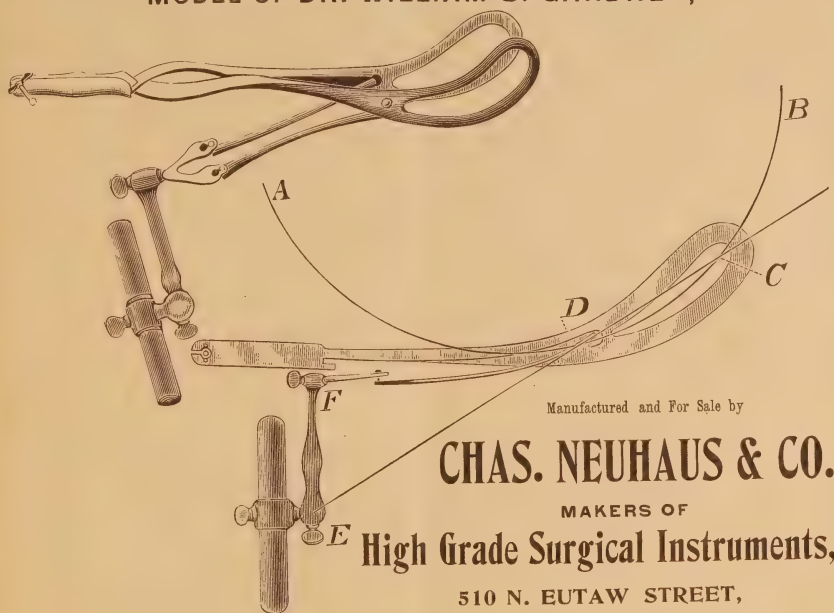
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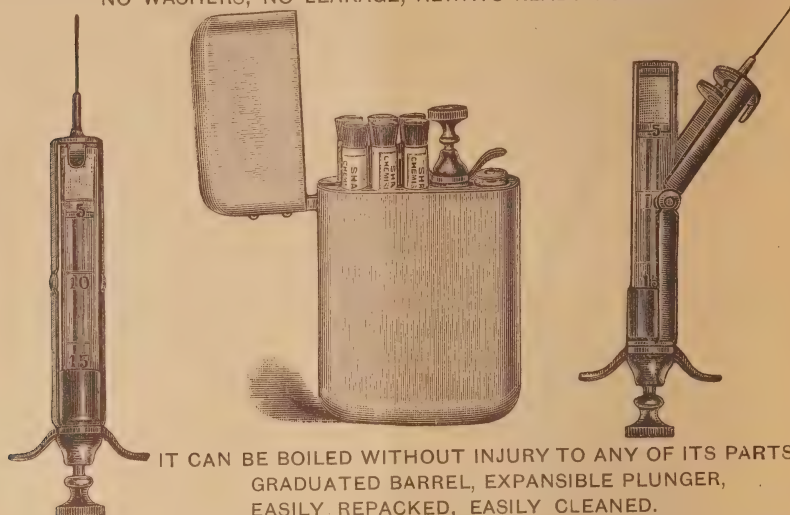
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THE MATERIAL NEEDS OF MEDICAL EDUCATION.

ADDRESS AT THE OPENING OF THE NEW BUILDING OF THE COLLEGE OF PHYSICIANS
AND SURGEONS OF BALTIMORE, DECEMBER 21, 1899.

BY DR. WILLIAM H. WELCH.

The opening of this new college building, in which provision is made for the teaching of medicine by modern methods, and especially for laboratory instruction, seems to me a fitting occasion to say something concerning the condition of medicine to-day, and particularly the material needs of medical education. In a country where appeal must be made to private beneficence for the support of higher professional education, it is important that the general public should be informed concerning the requirements for the best training of medical students at the present day.

The century now drawing to a close has witnessed a development in medical science and practice far surpassing that of all the centuries which have gone before. Of the half dozen great discoveries which in their day have revolutionized the science and art of medicine, only that of the circulation of the blood belongs to a past century, while surgical anæsthesia, cellular pathology, the demonstration of the germ doctrine of infectious diseases, antiseptic surgery, and the prophylactic and therapeutic applications of the principles underlying anti-

ficial immunity have all been introduced during the nineteenth century. As regards the last, a partial but important exception must be made in order to include the introduction near the close of the last century of vaccination against small-pox. Around these great discoveries, and for the most part dependent upon them, cluster a host of others, and all have combined to change the whole face of medicine. In all directions the stock of medical knowledge has been vastly increased, so that no man can grasp it all, and only a relatively small part can be taught to the student of medicine. Specialization with all its advantages and its defects has become a necessity both on the scientific and the practical sides of medicine. Each of the fundamental medical sciences is now cultivated both for its own sake as well as in its relations to other branches of medical knowledge. We know a great deal more than our predecessors of the structure and workings of the body in health and in disease. Our insight into the causes of disease, particularly of infectious diseases, has been deepened, and hand in hand with this increase of knowledge, although not in direct ratio to the scientific advance, has expanded the power of the physician and surgeon to prevent and cure disease. The ability to prevent the accidental infection of wounds has greatly advanced the surgeon's art and made it one of the most rewarding and beneficent of human pursuits. Not less striking is the increase in our power to check the introduction and spread of many infectious diseases. Civilized countries with proper systems of public sanitation need have little fear of the pestilences of former times. With the diminution in mortality from the diseases of early life, the incidence of disease is changing toward a preponderance in the diseases of old age. While on that side of the physician's activity with which the public is most familiar, the daily routine of general practice, the progress may seem less apparent, still here also there has been great improvement in methods of diagnosis and in the means of treating disease, even if we must admit that the untrained physician can now do harm in a greater variety of ways than formerly.

But it is only in contrast with past knowledge that the progress seems so great. If we consider what remains to be accomplished,

and what we may reasonably hope will be attained, we may well believe that the veil has been lifted only in relatively small part from the mysteries of disease and its prevention and cure. We cannot doubt that we shall advance further along paths already opened, as for example, in the direction of the specific antitoxic and antiparasitic treatment of infectious diseases, and that vistas of knowledge and power now undreamed of will be disclosed.

The great advances of the present century are due not to any improvement in the mental powers of man, but to the general recognition of the truth that the only way to learn the facts of nature is by observation and experiment. This scientific method of investigation seems to us so obviously the correct and fruitful one that we can only marvel that it was not equally apparent to our predecessors in past centuries. Of course from the most ancient times there have been those who have contributed to natural knowledge facts based upon observation, experiment and just inference, and we are the heirs of great scientific truths which have thus come down to us from past ages. But nothing is clearer to the student of the history of medicine and of science than the prevalence of the opinion, until comparatively recent times, that the secrets of nature could be learned by contemplation and reasoning. This erroneous belief, combined with reliance upon the authority of tradition or of some great name, was the great obstacle to progress and the source of the many speculative systems which are so difficult for us at the present day to comprehend, even if we think it worth while to make the attempt.

I cannot better illustrate the value formerly attached to mere reasoning as a basis of scientific discovery than to quote from one of the Essays of Jean Rey, Doctor of Medicine, entitled "On an enquiry into the causes wherefore tin and lead increase in weight on calcination," first published in 1630. These essays are of such interest and importance in the history of science that they have been recently republished by the Alembic Club. Rey to some extent anticipated the results of Lavoisier a century and a half later. His work is a curious combination of well chosen experiments and of metaphysical speculations. The quotation to which I call your attention is as fol-

lows: "My chief care hitherto has been to impress on the minds of all the persuasion that air is heavy, inasmuch as from it I propose to derive the increase in weight of tin and lead when they are calcined. But before showing how that comes to pass, I must make the observation—that the weight of a thing may be examined in two ways, viz., by the aid of reason, or with the balance. It is reason which has led me to discover weight in all the elements, and it is reason which now leads me to give a flat denial to that erroneous maxim which has been current since the birth of Philosophy—that the elements mutually undergoing change, one into the other, lose or gain weight, according as in changing they become rarefied or condensed. With the arms of reason I boldly enter the lists to combat this error, and to sustain that weight is so closely united to the primary matter of the elements that they can never be deprived of it. . . . But not presuming that my statements are on a parity with those of Pythagoras, so that it suffices to have advanced them, I support them with a demonstration which, as I conceive, all men of sense will accept. Let there be taken a portion of earth which shall have in it the smallest possible weight, beyond which no weight can subsist; let this earth be converted into water by the means known and practised by nature; it is evident that this water will have weight, since all water must have it, and this weight will either be greater than that of the earth, or less than it, or else equal to it. My opponents will not say that it is greater, for they profess the contrary, and I also am of their opinion; smaller it cannot be, since we took the smallest weight that can exist; there remains then only the case that the two are equal, which I undertook to prove."

This somewhat lengthy citation, upon which no especial comment is necessary, will suffice as an example of the study of nature by unaided reason and dialectics, and the interest attaching to it is enhanced by the circumstance that Rey himself made ingenious experiments in natural philosophy, and that he belonged to the century of Galileo, Kepler, Newton and Harvey, a century which has often been compared with our own in respect of interest in scientific discovery.

Rey, in the foregoing quotation, incidentally furnishes an illus-

tration of another characteristic of past systems of doctrine in science and medicine. You may have noticed that he implies that, if he possessed the authority of Pythagoras, his statements would be accepted without demonstration. This blind reliance upon authority is exemplified by the saying of one of the great Arabian physicians: "If Aristotle and Galen are both of one mind we may be sure of the truth; but if they differ, it is very difficult to determine what is true."

Systems of medical doctrine, which profoundly influenced practice, were thus constructed upon the basis of speculation and traditionalism. The Galenic system held sway for nearly fifteen hundred years, and was displaced by other systems which, although marking an advance in knowledge, rested largely upon dogma. The eighteenth century is often characterized as that of the great medical systematists, and during the first four decades of the present century German medicine was bound in the trammels of the so-called philosophy of nature. The greatest factor in releasing medicine from the shackles of dogma and turning it into the paths of science, was the foundation of cellular pathology by Virchow in the middle third of the present century.

It is of course not to be inferred that the exercise of reason, logical deduction and imagination is not essential to fruitful scientific inquiry. Indeed, it may well be, as pointed out by Clifford Allbutt in his admirable address on "Medicine in the Nineteenth Century," that we could learn much from the old dialecticians in the use of the weapons of logic, but experience has demonstrated that the real basis of progress in medicine, as in all the natural sciences, is the discovery of new facts by means of observation and experiment. It is by following the path thus indicated that medicine has advanced with such rapid strides during the latter half of the present century.

These great advances in medical knowledge, secured by the employment of truly scientific methods of investigation, have largely increased and modified the material needs essential for the promotion of medical science and for proper systems of medical education. It is of the highest importance that the general public, at least in this country, should be informed of the necessities of medical teaching and investigation, for if they want good doctors they must help to make them.

Medicine can no longer be adequately taught by the simple appliances of former times. As long as medical knowledge was essentially a body of tradition, about all that was necessary in the way of material equipment was a lecture room. Until comparatively recent times, the student was brought into direct contact with the objects of study only in the dissecting room and occasionally in the clinical amphitheatre. Gross human anatomy, being for centuries the only subject which the medical student could study by laboratory methods, acquired an exceptional position in the scheme of medical education. At the present time, instead of a single laboratory subject, there are at least eight subjects which require special laboratories or divisions of laboratories, and some of these are no less important than normal anatomy. These subjects are microscopic anatomy and embryology, physiology, physiological chemistry, pharmacology, pathology, bacteriology, hygiene, and clinical microscopy.

The lecture room no longer holds the dominant position. While the purely didactic lecture still has its place in medical teaching, this place is relatively a subordinate one.

It is important that the student should be brought into closer relation with the patient than was formerly the case. It is not sufficient that he may witness from a bench in the amphitheatre a surgical operation or the examination of a patient. He should be admitted to the dispensary and to the hospital wards, and should have opportunity to make personal examinations in cases of disease, and to follow the course and management of medical, surgical and obstetrical cases. He should be subjected to practical tests of his knowledge and power before he is launched upon the community as a qualified practitioner.

Now all of this requires suitable preliminary education, a period of professional study of at least four years, many and well-equipped laboratories, hospitals controlled by the medical schools or at least conducted in sympathy with the needs of medical education, and a large body of well-trained teachers. The greatest, although by no means the sole, difficulty in meeting these requirements of higher medical education has been the establishment of suitable laboratories. While we have a few good laboratories, there is no medical school in this

country fully provided with all the laboratories which it needs, and there is no single medical laboratory which possesses an endowment adequate to its needs.

A properly equipped laboratory requires suitable work rooms, a corps of trained teachers and attendants, supply of the material to be studied and of all the instruments, reagents and appliances needed for this study, access to books and journals, and funds for the purchase of fresh supplies and new instruments when needed.

The construction, equipment and organization of a first-class medical laboratory involve an outlay of money beyond the resources of a medical school dependent for its existence solely upon the fees of students, even when combined with the generous gift by the teachers of their services. In the State-supported universities of Germany three times as much money is devoted to the maintenance of laboratories as to the salaries of teachers. All honor to our own medical schools which, without the aid of State or of private endowment, are doing their best under great sacrifices to meet, so far as is within their power, the needs of modern medical education by provision for laboratory instruction and research! Of this generous and enlightened policy we witness a notable example here to-night in the opening of this building with its well-arranged laboratories.

The most remarkable progress in medical education in this country during recent years has been along the lines of more extended and improved methods of laboratory teaching, and I am inclined to think that the instruction in the scientific subjects of the first two years of the medical course, which was formerly the weakest, is now the strongest feature of our system of medical education. Those engaged in teaching these scientific subjects give in general a much larger share of their time to the work of instruction than do the teachers in the practical branches, and their courses are often better organized and more efficient than the clinical courses. The real aim of medical education should be the training of practitioners of medicine and surgery, and the benefits of thorough grounding in the fundamental medical sciences are to a large extent sacrificed if the student does not find in the latter two years of his undergraduate study well-conducted

clinical courses which afford opportunity for the practical application of knowledge previously acquired in the laboratories.

This is not a suitable occasion to consider the difficult problems pertaining to the arrangement of the medical curriculum. The entire content of medical knowledge is now so vast that only a relatively small part of it can be taught during the period of undergraduate study. Exactly what subjects shall be taught, in what order and how they shall be taught, and what amount of time shall be devoted to each are important matters, but they lie outside of my present theme. Of this much I am convinced, that it is of the first importance to impart to the student something of the scientific spirit, a real, living knowledge of the subjects studied, and the power to use the instruments of his profession. Thus trained, it lies within his power to continue an education which can only be begun at the medical school. It is in these directions that the educational value of laboratory methods, whether employed in the laboratory proper or in the hospital, is the greatest. In the laboratory the student learns the fundamental importance of accurate observation and experiment, here he finds that only that knowledge is living and stays by him which comes from direct contact with the object of study, and not from being told about it, or reading about it, or merely thinking about it, and here he becomes acquainted with methods and instruments essential for diagnosis, and, therefore, for intelligent treatment of disease.

There is or should be no real distinction in the spirit and methods of study between the laboratories of medical science and the hospital wards. One of the most important directions of development in our modern hospitals has been their close alliance with laboratories. The establishment of clinical laboratories in connection with hospitals has been, on the one hand, a great relief to other laboratories, and on the other, has conduced to improved diagnosis and more careful study of cases of disease, and has supplied admirable opportunities for the instruction of students. The resulting benefits to the patient have been inestimable.

As I have already indicated, the development of medical laboratories, from their modest beginnings with those of Purkinje and of Liebig in the second decade of this century, has been the natural and

inevitable result of the genuine scientific spirit, which distinguishes nineteenth century medicine from all that preceded it, and which has made it a biological science. The important discoveries in medicine during the century have been, on the one hand, the incentive to the foundation of laboratories, and on the other hand, and in still larger measure, have been the outcome of activities within laboratories.

While the expenses of a first-class laboratory are considerable, if we could estimate the benefits to mankind derived from investigations conducted in medical laboratories, all of the money ever expended for laboratories would seem in proportion to these benefits very insignificant. While it would be absurd to attempt to estimate in money the value of scientific discoveries, it would not be difficult to show that all the money ever expended for the promotion of medical and biological science has been repaid a thousandfold by the results of laboratory investigations in one department alone, namely, that relating to microscopic organisms, as witness the rescue of the silkworm industries of France by Pasteur's studies, the advantages to breweries, dairies and agriculture from the study of fermentative processes, the introduction of antiseptic surgery by Lister on the basis of Pasteur's discoveries, the saving of untold thousands of human and animal lives by preventive and curative inoculations in diphtheria, rabies, anthrax and other infectious diseases. The most important of the discoveries which have led to such results as these, and have opened up new vistas in medicine, have been made in Germany and France, where scientific laboratories are most numerous and best supported.

The last two decades of this century have been periods of unsurpassed fruitfulness in medical discovery. There is no reason to suppose that this activity will not continue and bring forth results beside which our present attainments will appear small. What patriotic American would not rejoice to see his country take a position commensurate with its size and importance in this great forward movement of medical and biological science? The surest and probably the only way to secure such full participation upon our part, is by the endowment of medical education and research.

There may have been in former times little that was attractive to

the philanthropist in the endowment of medical education. While the students of medicine greatly outnumber those of theology, and the expenses of medical far exceed those of theological education, the endowments of the latter in this country exceed \$20,000,000, whereas those of medical schools are less than \$1,000,000. The Commissioner of Education, in his report for 1890-91, commented as follows upon this contrast between the endowment of theology and that of medicine: "There can be no doubt of the propriety of private philanthropy endowing theological study, nor of the State's enterprise in supporting technical and pedagogical studies, but it is difficult to discover why such consummately practical and important topics as law and medicine should be neglected by private benevolence or public caution. It seems to be conceded that unendowed instruction in law or medicine will be just as poorly given as unendowed instruction in theology or pedagogy. Yet we find instructors in both these sciences, though necessarily State-supported on the Continent of Europe, in America left to live upon the meager diet of tuition-fees."

The needs of medical education have begun to be recognized by public-spirited philanthropists. I believe that there is to-day no direction in which private philanthropy can secure larger returns in benefits to humanity than by money expended in improvement of medical education and in the promotion of medical knowledge. Certainly it is the duty of physicians to make clear to the public the urgent needs of medical education, and if these needs are fully appreciated, it cannot be doubted that the small number of benefactors of medical education will be increased.

In conclusion, I desire to express my warmest congratulations to the Faculty, alumni and students of the College of Physicians and Surgeons of Baltimore upon the addition to their resources of this admirable building, which has been constructed with full appreciation of the value of laboratories in the training of medical students. Its completion is a matter of congratulation not to this College alone, but to the city of Baltimore and to all interested in the promotion of medical education. May this structure, now opened, long be the abode of sound learning, of good teaching, of active work, an attraction to students from far and near!

CASE OF TETANUS TREATED WITH ANTI-TETANIC
SERUM RESULTING IN RECOVERY.

BY DR. EDWARD V. MURPHY, '99.

Mrs. C. was admitted to the accident ward of the City Hospital July 19, 1899, suffering from a compound fracture of the right radius near the wrist, and also a fracture of the inner condyle of the humerus on the same side, the injuries having been produced by an assault with a poker.

The arm was placed in an angular splint and dressed again the following day. After the third dressing, July 25, the patient's temperature remained normal, previous to that time it never ran higher than 101° .

On August 7 the patient first complained of a slight stiffening of the left Masseter muscle near the zygomatic process. There was also a slight rigidity of the neck muscles. She compared the feeling as being similar to a stiff neck following a cold. She was unable to open her mouth to the normal extent and could not masticate at all. Although this was the first time she complained, upon close questioning, she admitted that the night previous she had felt uncomfortable about the jaws, but it did not bother her enough to cause complaint.

At this time the patient's temperature was normal, but the pulse began to grow weak and rapid, reaching 100. Patient was immediately given 30 cc. anti-tetanic serum.

August 8.—The posterior cervical muscles began to be painful and more rigid, and the patient was unable to open her mouth as widely as on the day previous. She could not protrude her tongue more than a quarter of an inch beyond the central incisor teeth. Any attempt to approximate her chin to her chest caused pain in the back of the neck. The muscles of the anterior aspect of the neck then began to become rigid. Anti-toxine 20 cc.

August 9.—Patient unimproved. The temperature began to rise gradually, reaching 101.5° . Pulse feeble and reaching 120. Anti-toxine 30 cc.

The following day 20 cc. of anti-toxine were given, but the patient was steadily growing weaker.

August 11.—Patient could open her mouth only slightly, the masseter muscles having become very rigid. For the first time she complained of pain in the abdomen and chest. The respiration was now noticed to be rapid and shallow, at one period of the day the rate of respiration reaching 45 per minute. On this day a 10 cc. injection of anti-toxine was given.

August 12.—A 20 cc. injection of anti-toxine was given. The pulse was gradually becoming weaker and more rapid, reaching 130 per minute. The respirations were still 45 per minute, and the temperature for the first time reached 104° . This was the condition August 13, after a 20 cc. injection of anti-toxine was given.

August 14.—The first signs of improvement were noted. The patient was able to open her mouth with less difficulty, and the tongue could be protruded a greater distance than at any time during the attack. The pulse had dropped to 105, but the respiration still remained rapid and shallow, never being less than 40 per minute.

August 15.—Patient's appetite had improved. She was able to masticate soft food. All of the neck muscles were less rigid and the general condition of the patient was most promising. From this time the improvement continued. The breathing was less labored and deeper; the temperature dropped to 99.5° and gradually reached normal. The pulse was less rapid and firmer. The pain in the abdomen and chest was relieved and all symptoms of tetanus disappeared. Ten cc. injections of anti-toxine, twice a day, were continued until August 18, when treatment was stopped. At no time did the patient suffer from any general convulsions, the attack seeming to center around the jaw and neck muscles with a slight involvement of the muscles of the abdomen and chest. It was impossible to state whether the attack was acute or chronic. The first symptoms of the disease developed 17 days after the injury to the arm. Tetanus had been introduced into the hospital by a man who had received a scalp wound by being thrown from an electric car into a pile of bricks. It is believed the infection of Mrs. C. took place during one of the dressings after the arm had been set. The prompt use of the anti-tetanic serum was followed by a perfect recovery, whether the tetanus was of acute or chronic origin.

ADVICE TO GONORRHEAL PATIENTS.*

BY DR. W. L. CHAMPION, '91.

Mr. President and Gentlemen:

I have a very short paper, with a time-worn subject, which I wish to present, hoping it will bring forth a full and free discussion, benefiting us all.

By the laity gonorrhea has always been considered a very insignificant trouble, easily cured without any serious after-effects. Because the disease does not directly produce death, a large percentage of the members of the profession are prone to view the trouble in the same light.

When we consider the serious train of troubles that result from gonorrhea, such as stricture, involvement of the testicles, bladder and kidneys, rheumatism, the large number of people in the blind asylums directly due to gonorrheal ophthalmia, and the pelvic diseases in women due to gonorrheal infection, it impresses me that the profession should awaken to the important fact that the laity should be informed, not only of the highly infectious nature of the disease, but the number of invalids produced by such infection. We can, in a measure, accomplish this result by teaching our patients not to contract the disease, its serious nature, to go to the physician for treatment, not to the druggist, and that there can be no question that the disease is cured before sexual intercourse. Now, some may say that advice of this kind to a patient is worthless, but the physician can and does have some influence over his patrons, and good advice in this direction will be worth something to humanity. We know the disease will always be with us, but we can and should strive to suppress it in some degree.

The question has been asked, Is gonorrhea ever cured? Does the urethra ever return to its normal condition after an attack of the disease? The fact that gonococci remain dormant in the urethra for years would make the above question pertinent. I recently had a patient (married man) to come for treatment who had a urethral stricture which was due to a case of gonorrhea contracted fifteen years before. There was no discharge from urethra and urine was

* Read before the Atlanta Society of Medicine, Oct. 5, 1899.

very nearly clear of clap-shreds. A sound was passed into the bladder and the next day there was a profuse purulent discharge, which was examined microscopically and gonococci found in abundance. Of course we cannot believe the statement of every patient with a venereal disease, but this is only one case of quite a number that I could cite where gonococci remained in the urethra for years. That the gonococcus is the cause of gonorrhea there can be no doubt, and it is a fact that gonococci do remain in the urethra for a long period of time, and though they may be inactive, any slight irritant or a decreased resistance of the tissues to the poison, will cause a fresh outbreak of the disease. In my opinion, what is generally termed a "bastard clap" is an acute exacerbation of a chronic condition. We do see, though very rarely, cases of non-specific urethritis due to irritating discharges, strong injections, improper use of instruments or highly acid urine, and not due to the gonococcus. Now we can determine positively that the gonococcus is not present when we set up a discharge in the urethra and the examination shows a negative result. That the urethra does return to its normal condition after a specific infection, as does the lung after pneumonia, can be demonstrated in over fifty per cent of cases taken in time and properly treated. That this is true can be shown by careful examination with the bulbous bougie or ocular inspection through the urethroscope. A urethra that is badly strictured never returns to its former anatomical condition from either medical or surgical treatment; but a badly strictured urethra can by proper treatment be enabled to perform its functions satisfactorily freed from gonococci, will not shorten life and is without the probability of recontracting.

Years ago, and to a large extent at the present time, the acknowledged course to pursue in the treatment of an acute "clap" was to give some mild saline draught until the acute symptoms subsided and then commence active treatment. It is just as reasonable to wait for acute symptoms to subside before commencing treatment in gonorrheal ophthalmia as in gonorrheal urethritis. The foundation for a urethral stricture is formed in the acute stage of the disease, and in proportion to the intensity of the inflammation is the liability to stricture follow-

ing. The proper course to pursue is to commence treatment as soon as the patient presents himself, and the disease is cut short while we are waiting for the acute symptoms to subside.

It is always the physician's duty to look to his patient's interest and give him the best treatment possible. That better results are obtained by having the patient report to the office daily for treatment instead of giving him medicine to use will not be questioned by any one who has given it a trial. I will not go into the treatment, as I read a paper before this society in January, 1888, on the Treatment of Gonorrhea by Hydrostatic Irrigation.

The physician should by all means strongly impress upon the patient the highly infectious nature of the disease, also the frequency with which the disease is apparently cured only to break out afresh, and the very important point of avoiding sexual intercourse until entirely cured. A test as to whether a urethra is inflamed, and one that should always be made, is too frequently overlooked, that is, the presence of clap-shreds in the urine. I never dismiss a gonorrheal patient until the urine is free of these shreds.

A physician is very neglectful of his duty if he dismisses a gonorrheal patient without carefully examining his urethra for stricture. The inflammatory area around a stricture is a hotbed for gonococci, and all that is necessary to arouse them from their dormant state is a slight irritant. When a patient has had a recent gonorrhea or there is any indication of an inflammatory condition of the urethra, a solution of nitrate of silver should be thrown into the urethra to set up a discharge, so it can be examined for the gonococcus. This should by all means be done when the patient contemplates marriage. I feel safe in stating that every one of us in this hall to-night would be surprised to know the number of innocent wives infected by their husbands who have an apparently cured specific urethritis. If Eve was truly the cause of Adam's eating the forbidden fruit, womankind has since suffered sufficiently on account of man's ignorance or "cussedness" in infecting woman.

It is true that the majority of men look upon a discharge of pus from the urethra as pathological, but a urethra may contain gonococci

when the morning drop is not present. As far as the presence of pus is concerned, this does not hold good with women, and as Prior has said, "We should persuade them to look upon pus from the genitals as having the same significance as pus from other localities." My experience has been that 95 per cent of male patients with a purulent discharge from the urethra, no matter how slight the discharge, nor whether due to a stricture or not, contains gonococci. As already stated, throwing a strong solution of silver nitrate into the urethra and examining the discharge produced without finding the gonococcus, is a safe test that the canal is not infected. Still, this will not hold in every case unless we examine carefully to determine whether the small glands and follicles are still involved. To show the importance of a careful examination in every case I will mention one I now have on hand. A young man contemplating marriage came for treatment. He had a chronic urethritis; examination showed discharge replete with gonococci. After six weeks' treatment endoscope showed healthy condition, urine free from clap-shreds, discharge produced by silver nitrate examined and gonococci absent. A few weeks later this patient presented himself with a folliculitis, a small abscess beside the frenum with no inflammation of urethra. Pus from this abscess was examined and gonococci found. In this case there was a single point of infection in a small gland from which no doubt the wife would have been infected should the patient have married. This case illustrates the importance of a careful examination in every respect before dismissing a patient.

While these apparently little facts are probably known to all of you, we occasionally in the hurry of business overlook them. If I can influence some member of the profession to treat his patients, not allow the patients to treat themselves, see them daily with the necessary examination, impress upon them the untold misery they will produce by infecting others, and the importance of knowing they are well before treatment is stopped, I shall feel I have accomplished something.

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IN A FIELD HOSPITAL.

The gruesome tales of the horrors of Chickamauga have, no doubt, long ere this, faded from the minds of those who gained their information from the newspapers and other periodicals; but for those who lived and worked in the fever hospitals of the army of detention, the name of Chickamauga calls up many pleasant memories.

It is now a pretty well-known fact that these tales were somewhat exaggerated, as testified by the following, gleaned from the diary of the Sisters of Mercy of the Baltimore City Hospital attached to the College of Physicians and Surgeons. The Sisters had, when the first cry of the suffering soldiers reached their ears, offered to care for the Maryland troops here in their own hospital, as well as to go to the detention camps and nurse the sick there; both offers were accepted by Surgeon-General Sternberg.

On Saturday August 20, 1898, they left Baltimore, arriving at midnight, August 21, at Chattanooga. No sooner did they step upon the platform of the station than they found work to do; for there, in the waiting-room for "colored people," were about fifty sick men, on cots and stretchers, waiting for a hospital train. They had been lying on the open platform of the freight station from six to ten P. M., when they were removed to the waiting-room. They had no physicians with them, and were attended by several male nurses of the Hospital Corps. Upon inquiring, it was found that these men had been given no nourishment in all that time; the nurse protesting that he could not get any for them; finally, he was persuaded to go to the eating-room adjoining and procure sufficient milk to give every man a drink, and something more substantial for those who could take it. When the Sisters left in the morning, the hospital train had not yet arrived.

It is nine miles from Chattanooga to Chickamauga Station, on one of the most dilapidated railroads of the South. The Sisters remained one day at the Sternberg Hospital, and then Colonel Hoff, the division surgeon, took them, where they were more needed, to the Third Division Hospital, First Army Corps. This hospital contained five

hundred patients; the majority, acute cases of typhoid, the remainder had malaria or a peculiar camp fever, jaundice, and measles. It was poorly equipped in every way; first, it was located in the woods on low ground, which, after every rain, formed stagnant pools that soon became offensive. A new portion in the form of a double cross had been commenced, but orders had been received to stop work, so that some portions of the floor were loose boards which rattled at every step, and other parts were not floored at all, making it impossible to keep bedclothing out of the dust and mud. Now, a tent makes an ideal ward, if situated upon high ground in the open sunshine. The beds were of all sorts; principally canvas cots which stand not more than eighteen inches above the floor; then there were eight in a tent about fourteen feet square, so that the bathing of patients was a matter of no little difficulty, especially when there were no sponges, few towels, and one basin among three or four Sisters. Bed-linen, etc., were also at a premium; the washing, so called, being done by hand by a few negroes in the park. To keep off flies and mosquitoes, they had small pieces of net, which were generally so annoying by contact with the face that the majority of the men discarded them altogether.

Chickamauga Park is a delightful camping ground if not too crowded; but the volunteer soldier is ignorant of the laws of hygiene and knows no self-restraint; it takes the strict training of the regular army to teach him that. Consequently, the wonder is, not that so many were sick, but that so few died.

"Before we set out, Professor Bevan gave us some general directions with regard to preserving ourselves from infection; impressing on our minds to be sure and wash our hands in the three antiseptic solutions after handling patients, etc. Well, we were glad enough to get a basin and soap to wash our hands before meals; and for antiseptics, well, the following was the method of disinfecting in vogue on our arrival: The sink was dug about a hundred yards from the hospital; beside its open mouth stood a barrel of lime; all vessels were emptied there and plentifully besprinkled with lime each time, then thrown on the ground outside the ward; they were never washed.

One can readily imagine the condition of the bed-linen, and the excoriated backs of the poor patients. The flies swarmed in millions, and were potent factors in the spread of the disease.

"A few weeks soon changed the face of affairs. Major Louis Brechman, M. D., of the regular army, took charge about September first; he was a student at the College of Physicians and Surgeons in the early nineties, and always called the Sisters of Mercy "my sisters," because we were from the City Hospital. A new hospital was erected on an elevated open space, and consisted of three wards, each twenty tents in length, every alternate one being a "fly," that is, merely a canvas roof, and these were not occupied by patients. We had but five patients in each tent, and the wards were better equipped with the necessary furnishings. The floors were scrubbed every day with carbolized water, and the furniture wiped off with a cloth sprinkled with turpentine. Bed-linen and night-shirts were changed daily, and were sent to a steam laundry in Chattanooga.

"A unique crematory was built; it consisted of an excavation about ten feet deep in the side of a hill; three grates were laid one above the other, made out of old railroad rails. Wood fires were built on all three grates, and kept roaring day and night. A large zinc tub of water containing bichloride was kept boiling on one corner, and all vessels, after being emptied into the fire, were plunged several times into the boiling water, and on returning to the wards were placed on shelves outside. Previous to this it had required no little labor to remove the lime, etc. Nothing was allowed to be thrown on the ground, not even a basin of water; all had to be carried to the crematory; any particularly foul bed-linen was also burnt. In fact, the oldest part of the old hospital, including a large number of blankets, had been made a grand holocaust. No lime was sprinkled around, as that would have been evidence of unsanitary conditions.

"The methods of treatment were as varied as the number of physicians; and they were allowed full liberty in this respect. Of course the nurse has nothing to do but to follow directions; but, other conditions being equal, those physicians had the better success who had experience in hospital practice.

"The diet, both of the sick and well, has been loudly condemned. Now, the food supply for the hospital, at this time, was quite sufficient both in quantity and quality; for what the commissary department did not supply, the Red Cross Society did; so that we had a variety of canned soups and broths, as well as the usual eggs, milk, etc. The milk at our hospital came from the Biltmore estate. But, whatever success woman may achieve in public life, man is not fitted to attend to domestic concerns; so, until woman arrived on the scene of the fever-camps, the diet was badly prepared, and still worse served; of course, there were some exceptions to this, as witnessed in the diet-kitchen in Second Division Hospital, Knoxville, Tennessee. Here the cooks in both diet-kitchens of the acute and the convalescent wards took every pains to have the food nicely prepared and served.

"Neither is man fitted to be a nurse, for the majority have very little sympathy even with a fellow sufferer; and this is the one evil of the detention-camps that deserves the severest reprobation; namely, the brutal neglect of the sick by the very men who had enlisted for the avowed purpose of nursing them. It is true, that some of the members of the Hospital Corps were men detailed from the regiments to do hospital work, when they had enlisted to fight; yet many others had been orderlies in hospitals, medical students, and even a few graduated physicians. Some of these latter we have seen do noble work; others again were as careless as the most ignorant, but they were not P. & S. men.

"The medicines also came in for a share of condemnation; but wherever we were, Uncle Sam supplied all the drugs that were needed in abundance and of the very best. It is claimed that in the beginning there was a scarcity of supplies of every kind, and a lack of many things; but that was the original sin of the whole war—they mobilized before they were fully prepared. But, notwithstanding our many hardships, we shall look back on our sojourn in Chickamauga and other Southern camps with sweet memories of sufferings alleviated and hearts made glad."

S. M. N.

THE TREATMENT OF SYPHILIS BY THE GENERAL PRACTITIONER.

BY DR. HARVEY P. JACK, '91.

Continued from No. 3.

Prof. Hyde gives us a different figure, claiming that syphilis proceeds outward in radii, not in parallels, from the chancre syphilis as a center, and that their general direction differs from each other markedly and at an early moment in the career of the disease. He divides these radii into four categories or excursions:

1. Benignant syphilis, with few and mild transitory symptoms, probably including the smallest number of patients. The cases are mild, the symptoms insignificant, the issue simple. These cases do not react with the syphilitic poison; the germ has found in them an uncongenial soil.

2. Benignant syphilis, with severe relapsing but transitory superficial symptoms. These cases suffer from a recurrence of mucous patches and eruptions but finally escape.

3. Malignant syphilis, with scarring and cachexia. Cachexia furnishes the real stigma of this direction of the course of syphilis. The gummatous lesions do not show a malignant tendency. Cases are often removed to one of the classes named above, but either, in consequence of poor treatment or none, or an enfeebled constitution, the case often lapses into the last class.

4. Malignant syphilis, with persistent, deep-seated, gummatous lesions. The great majority of cases seen by the general practitioner come under the first two groups, and almost all cases under the first three groups.

It seems to me that this classification helps us greatly in estimating the best methods of treatment. Although in the past it has been considered impossible to estimate in the early months of infection the course of syphilis, whether it would be mild or malignant, the opinion is gaining ground among specialists that we can, to a very great extent, predict the future from the early symptoms. This opinion is shared by Fournier, Keyes, Hyde and Horwitz. If this be true, which

I believe, and which is becoming generally believed from long observation by these and other specialists, it is a matter of vital importance both as to marriage, life insurance and treatment. Hyde says: "Given a man who is most likely to escape gummatous complications, and we shall find, first, one who is young; second, one who has good habits; third, one who has inherited a good constitution; fourth, one who has a good family record." In addition to the above given by Hyde, most observers would add a small kindly healing initial lesion.

Given a man who is about to suffer from gummatous complications and we shall find, first, one who has passed the early period of life often infected in middle life or in advanced years; second, one whose habits are bad with respect to either debauchery or drink; third, one whose constitution has been vitiated either by inheritance or his mode of life; fourth, one who is in a cachectic state when infected, or what is, for our purpose, one who is unduly fleshy. Again, most observers, including Fordyce, would add a large œdematous initial lesion as a predisposing factor.

So much for a general discussion of the course of syphilis.

The treatment of syphilis naturally divides itself into first, abortive; second, preparatory; third, anti-syphilitic.

The abortive treatment of syphilis as at present practiced is divided into (1) excision of chancre, (2) cauterization, (3) hypodermic injection, local.

Of excision it may be said that while most syphilographers are of the opinion that it is of no effect as an abortive method, still some men of eminence claim for it positive results, and in view of the demonstrations of Beauchard and Chaveau, that the severity of the disease is in direct proportion to the intensity of the injection, and the belief of Finger, "That the innocuity of the primary stage is due to tissue products of the virus in the circulation, the infected foci being still strictly localized," the severity of the syphilis being due to the dosage of the poison, it is recommended by Horwitz in certain cases as routine practice. These cases are those in which excision will not deform the part; where the chancre is seen within four days after appearance; where examination of the woman is possible and is made and

she is found syphilitic. The operation is simple and easily performed, most operators simply picking up the chancre and rapidly dissecting it off with scissors, after injecting with cocaine or freezing, and then cauterizing with nitric acid and applying a simple dressing. Wound usually heals rapidly. In cases in which this was done the succeeding symptoms were in all very mild, but out of 26 in only two was there absence of symptoms following, and Horwitz believes that in these the diagnosis was wrong, and, further, all the syphilis he was treating at that time was mild. Nevertheless, as there is still some doubt of its efficacy within the above limitations, and where the case has been fully stated to the patient, it is recommended by both Hyde and Fournier that we give the patient the benefit of the doubt and excise the chancre. Cauterization alone has proven itself to be ineffective. I have read a report of a case in which cauterization was performed, within an hour of cohabitation, of a tear in the frenum which terminated in syphilis in due time.

Treatment by hypodermic injection at the base of the chancre and into the enlarged lymphatic glands has been recommended and tried upon the belief that the chancre was the storehouse of the germ, but found wanting in that it did not abort the disease, but did render the succeeding symptoms extremely mild. So mild, says Horwitz, that he did not know when to discontinue treatment or how to give a correct prognosis.

It seems to me that this is a very weak argument for condemning this method in cases past the time for excision and of undoubted syphilis, proven by confrontation of the woman.

Why not put these cases on the tonic treatment of Keyes by mercury and keep them there three years anyway, when the case has proven undoubtedly to be syphilitic; and Keyes has shown the tonic treatment to be harmless and even beneficial?

While I can see that as an abortive measure it has failed, I cannot see why in cases in which the administration of mercury is to be begun anyway before the advent of the eruption, cases which will be hereafter detailed as the exceptions to the rule of waiting until the eruption and mucous patches and alopecia are present.

I have had experience with this method in one case, one in which the circumstances were peculiarly distressing. A young married woman had become infected from a man whom I knew to be in the active period of the disease. The chancre was typical and something must be done. I saw the chancre early and at once injected one-quarter grain bichloride of mercury into the base of the chancre and made five injections in its neighborhood and into the glands of a like dose on succeeding days, after which mercury was administered internally. She had almost no symptoms of syphilis; occasionally a few mucous patches and a few macular syphilides. Although not of good constitution physically, she is now better than ever before in her life, and her husband did not contract the disease. I believe in such cases that this is good treatment. Attack the poison everywhere possible. We have the best authority for attacking it at this point. I believe the result justified my procedure and I would do it again.

The treatment of the chancre proper when in doubt as to diagnosis, as we almost always are until the appearance of secondary symptoms, so-called, is expectant and similar to the treatment of any other ulcer. A simple dusting powder of calomel, bismuth and salicylic acid I have found very effective, always cautioning the patient against removing the powder oftener than twice daily and then only by the gentlest methods in order to preserve the tender granulations. Hydrogen peroxide is a good cleansing agent to use previous to applying the powder. Iodoform, except for its odor, is one of the very best dressings. Iodol is of value. I have a case now under treatment which failed to do well under any thing but the first-named dressing. Horwitz recommends a powder like it with the exception of the salicylic acid. Under no circumstances should mercury be given until the diagnosis is beyond question, until the appearance of symptoms sufficient to convince you and the patient of the undoubted existence of syphilis; except in cases similar to the one related above, or in the case of married men, or where the sore takes on a sloughing phagedenic turn, or where for other reasons, but they should be very potent ones, it is necessary that no symptom or eruption make its appearance, or where the chancres are in the throat or meatus and liable to interfere with micturition or deglutition.

To be continued in the next number of the Journal.

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THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

STATE BOARD EXAMINATIONS.

Government control of who shall and who shall not be licensed to practice medicine conduces both to the elevation of the standard of minimum requirements of the candidates and also protects the public from having inefficient men turned out upon it. But there is no good reason why this control should be made to bear heavily upon physicians who having passed one state board wish to remove to another state. It is well known that few physicians who have been ten years in practice could pass without much preliminary revision the examinations in physiology, anatomy and chemistry. The members of the faculties of the various medical schools are very few indeed who could pass the ordinary college examinations.

There are two ways to obviate this unnecessary hardship. One way is to have a national board of examiners, whose certificate would be recognized in every part of the United States.

Another and perhaps more practical way is for states and territories having similar requirements to accept each other's certificates. A movement was recently started by the Wayne Co. Mich. Medical Society to bring about the legislation to put this plan into effect. It is hoped that the legislative committees of the various state societies will give this matter their immediate and earnest attention.

IMPORTANT TO OUR ALUMNI.

Subscribers to the JOURNAL should notify us promptly of any change of address. Notice must reach us before the first of the month preceding the date of the next issue of the JOURNAL.

Under a recent act of Congress, paper mail will not be forwarded to a new address, no matter whether instructions are sent to the local postoffice or not, unless addressee also sends stamps to that office to prepay cost of remailing.

Letters are forwarded without trouble. Papers, however, must be paid a second time if they are to be forwarded.

DR. WILLIAM J. TODD, *Business Manager*,
Postal Station No. 202,
Baltimore, Md.

The attention of the alumni is called to the fact that the next issue of the JOURNAL will contain the announcement of the commencement and the annual alumni meeting. No announcement except through the JOURNAL will be made.

Personal Notes.

DR. B. F. COE, '95, has removed to Gazen, Pa.

DR. J. M. JOHNSON, '96, is practicing at Coalport, Pa.

DR. T. A. COUNCILL, '94, spent three weeks in November shooting in North Carolina.

DR. ALEXANDER L. RANSOME, '75, died the past summer at Hyattstown, Md., aged 52 years.

DR. W. H. DALE, '95, of Hantzdale, Pa., brought a patient to the City Hospital in November.

DR. L. L. DOANE, '86, formerly assistant resident physician at the Maternité, is located at Kane, Pa.

DR. DAVID DAVIS, '86, resident physician at the Maternité in 1886-87, is now practising in Philadelphia.

DR. T. B. PERRY, '85, passed assistant surgeon in the Marine Hospital service, is now stationed in Baltimore.

DR. OWEN H. KEENAN, '95, is one of the internes in the Hospital of the Post-Graduate Medical School, New York.

DR. GEO. A. LANKFORD, '92, who was practising at Houston, Harris County, Texas, was killed by his wife, Nov. 30.

DR. MONMONIÈRE ROWE, '81, after having practised in Somerset County for several years, located in Baltimore in June.

DR. U. P. WHITE, '94, has removed from Chauncy to Athens, Ohio. The doctor and his wife paid a visit to Baltimore recently.

DR. W. L. HENDERSON, '95, has located in Baltimore and is working in the department of Diseases of Children in the dispensary.

The list of the alumni whose present addresses are not known is constantly increasing. If each alumnus who receives the JOURNAL would send us the address of all that he knows of, the list would soon be complete.

DR. M. A. BAILEY, '93, of Hartford, Conn., has had suit brought against him for failing to be present to attend a case of labor for which he was engaged.

A child was born which lived but a short time, and the father, as administrator of the child, sues to recover \$5000 damages from Dr. Bailey for alleged breach of contract.

At last report the outcome of the case had not been determined, but it is hardly likely that the father can recover damages for breach of contract that was not made with a child that was not yet born.

A students' medical society which has been organized at the college has been doing some excellent work. The program for the meeting of Dec. 19 was:

DR. J. J. Chambers, '84, "Medicine in the Klondike."

Mr. Shea, "A Case of Disease of the Mastoid Process."

Mr. Norris, "A Case of Dermatitis Exfoliativa."

Mr. Black, "A Case of Aortic Aneurism."

Mr. Fredericks, "Gelatin Injection in Aneurism."

Dr. Barrett, "A Case of *Æsophageal Stricture*."

As will be seen from this program, the major part of the papers read are reports of cases written by the students. These cases are assigned to the students by the clinicians, and a paper is then written and read by the student describing the particular case and reviewing the usual course of the disease. There are several commendable features in this work. It cultivates independent powers of observation; it gives practice in the art of correctly imparting what is observed; it impresses permanently that one disease upon the reporter, and all present reap some benefit from his work.

DR. R. SUMPTER GRIFFITH, '86, writes:—I attended the meeting of the Virginia State Medical Society in Richmond in October. The College of Physicians and Surgeons was well represented. Dr. Priddy, '86, is an ex-vice-president. Dr. Martin read an interesting paper. Dr. Priddy will be a member of the Virginia legislature this winter. I am serving as Mayor of Bassic City for the third term. I am company surgeon for the N. & W. R. R. and have a very good practice.

ALGOMA, W. VA., Oct. 5, 1899.

WM. J. TODD, M. D.,

Postal Station No. 202, Balto., Md.

Dear Doctor.—Enclosed you will please find check for \$2 for the ALUMNI JOURNAL. I derive more pleasure in reading JOURNAL than I do from any Journal that reaches my desk. The world has been kind to me since I left college, for I have all I can do, and I suppose have had the usual good luck that seems to follow all the boys from the P. & S. I regretted very much to hear of the death of our late and much-beloved Prof. Rohe. I shall pay the college a visit this winter and try and feel as I did when there from '92 to '95. We have in this county, McDowell, at least ten P. & S. men, and all are doing nicely.

Yours truly,

D. H. THOMAS, '95.

PITTSBURG, PA., Sept. 25, 1899.

DR. CHARLES E. BRACK, Balto., Md.

Dear Doctor.—Please find herewith enclosed one dollar for Alumni dues. The JOURNAL comes regularly and is always enjoyed. Please change my address from 1824 Webster Avenue to 5604 Penn Avenue. Our alumni here are all able to keep the “wolf from the door.”

Yours fraternally,

E. C. STUART, '87.

STAR, TEXAS, Oct. 18, 1899.

WM. J. TODD, M. D., Baltimore, Md.

Dear Doctor.—Dr. J. Bynum Triplett, '88, died very suddenly at Elk Park, N. C., a few days ago. He was an old friend of mine and I will write you particulars with short obituary in a few days.

Yours fraternally,

U. E. G. DYER, M. D., '92.

PROVO CITY, UTAH, Sept. 25, 1899.

DR. W. J. TODD, Mt. Washington, Md.

Dear Doctor Todd.—Enclosed find \$2 to cover enclosed bill, which please receipt and return. Doctor, it would do me much good to shake your warm hand and look into your genial and kindly face and chat with you a little while. This is a pleasure which I trust is in store for me in the near future. I am prospering and hope you are. I have a son and two daughters and hope you have. Drop me a line. Present my regards to your wife. We like the JOURNAL very much.

Your friend,

SAMUEL H. ALLEN.

GAINESVILLE, FLA., Oct. 12, 1899.

DR. WM. J. TODD, Baltimore, Md.

Dear Doctor.—Enclosed find \$1 to pay for the JOURNAL of the Alumni Association of the College of Physicians and Surgeons for another year. The JOURNAL is a highly creditable publication. It may interest some members of the Assn. to know that I am president of the Florida Medical Association.

Yours very truly,

J. HARRISON HODGES, '88.

CITY HOSPITAL OPERATING-ROOM.

In keeping with the vast improvements instituted by the College of Physicians and Surgeons, alterations and additions have been made in the Baltimore City Hospital which now render this institution second to none in the country as regards convenience and latest appliances. This hospital is under the charge of the Sisters of Mercy, and the building is a standing monument to the charity and beneficent work of this religious order. No pains nor expense have been spared to equip the hospital so as to provoke words of commendation and praise from all visitors who inspect the edifice.

The acme of perfection has been reached in the new operating-room in the hospital. No one can conceive its elegance until it is inspected. It is situated on the fifth floor, having dimensions of 50 by 25 feet. It is divided into three compartments by slabs of Italian marble seven feet high. The central apartment is used for the operations. The floor throughout is tiled with imported vitrified tiles, the wainscoting being composed of Italian marble to the height of seven feet. The joinings of the slabs with each other and with the floor are so rounded that there are no sharp corners where bacteria-laden dust can accumulate. The ceiling is enameled and the whole lighted by an arched window 20 feet high and 12 feet wide, consisting of hammered glass. In the way of instruments and appliances nothing is wanting, and the surgeon in the performance of the most intricate and delicate operation can ask for any instrument and it is at once furnished him.

On each side of the operating apartment is a division, one of which is used for anæsthetizing and can be completely isolated from the remaining portion, so while one operation is in progress another can be undergoing preparation.

The division at the other side of the room is used for a dressing apartment for the surgeons, their assistants and visitors.

Adjoining this large operating-room is the sterilizing department, which is 15 feet long and 10 feet wide. Here the instrument-maker was instructed to equip it with every convenience that modern science

had proven to be a success. The sterilizer for the dressings, the instrument-sterilizer, and the apparatus for the production of filtered sterilized water for flushing, prove that the instructions were carried out most scrupulously. All the sinks are porcelain, and the hot and cold water are under the control of the foot, so that the surgically clean hands of the operator need not touch anything that is not sterilized.

Leading from the sterilizing-room is the linen-room, and the well-stocked shelves show that nurses of experience have charge of the department that renders modern surgical operations antiseptically clean.

There is no drain under the operating-table where micro-organisms can congregate, but the necessity of it is obviated by so constructing the floor that there is a gentle incline of $2\frac{1}{2}$ inches in the 50-foot floor, so that the waste material gravitates toward the drain located in the sterilizing-room.

On the whole the room is a marvel of modern improvements, and no surgeon or interested person should visit Baltimore without embracing the opportunity of inspecting this perfectly managed and thoroughly equipped operating-room at the City Hospital.

OPENING OF THE NEW COLLEGE BUILDING.

The formal opening of the new building of the College of Physicians and Surgeons took place Thursday evening, December 21, 1899.

Over 500 visitors gathered in the large amphitheatre to enjoy the exercises that were arranged for the occasion. In the pit were the faculty and the guests of honor. Among the latter was Mayor Hayes, also Professor Welch of the Johns Hopkins Hospital, who was the orator of the evening.

Prayer was offered by Rev. Francis X. Brady of St. Ignatius Church.

At 8.30, Dr. Thomas Opie, Dean of the College, who presided, made

a short opening address in which he traced the progress that had been made by the College since its inauguration. At the close of his remarks he introduced Mayor Hayes.

The Mayor spoke of the high standard that had been attained by the College, and the excellent character of the work that had been accomplished by its graduates. He referred to the obligation a good government was under to take care of the health of the people, mentioning the necessity of having none but the most competent men in charge of that most important branch—the Health Department. He closed his remarks by speaking of the commendable work that was being done by the City Hospital.

Dr. Charles F. Bevan, chairman of the Building Committee, then gave a short description of the buildings that had harbored the different classes of the College, from the first building that occupied the site of the “City Spring” up to the present magnificent structure that is the pride of every member of the College Alumni.

Dr. William H. Welch of the Johns Hopkins Hospital, delivered a most interesting and instructive address. (See page 97.)

At the conclusion of his remarks, the College building and hospital were inspected by the visitors. Everybody embraced the opportunity of viewing the modern structure, and all united in admiration of the up-to-date equipments with which all departments were furnished.

The facilities furnished by the City Hospital were a revelation to many of the visitors. The spotless appearance of the wards bespoke the interest and care of the Sisters of Mercy and nurses. A visit to the operating-room on the fifth floor of the hospital completed the tour of inspection, at the conclusion of which the guests gathered in the Students' Library, where a repast was served by Caterer Harris. The evening was most delightfully spent, and each departing guest felt that the occasion had furnished him both entertainment and instruction.

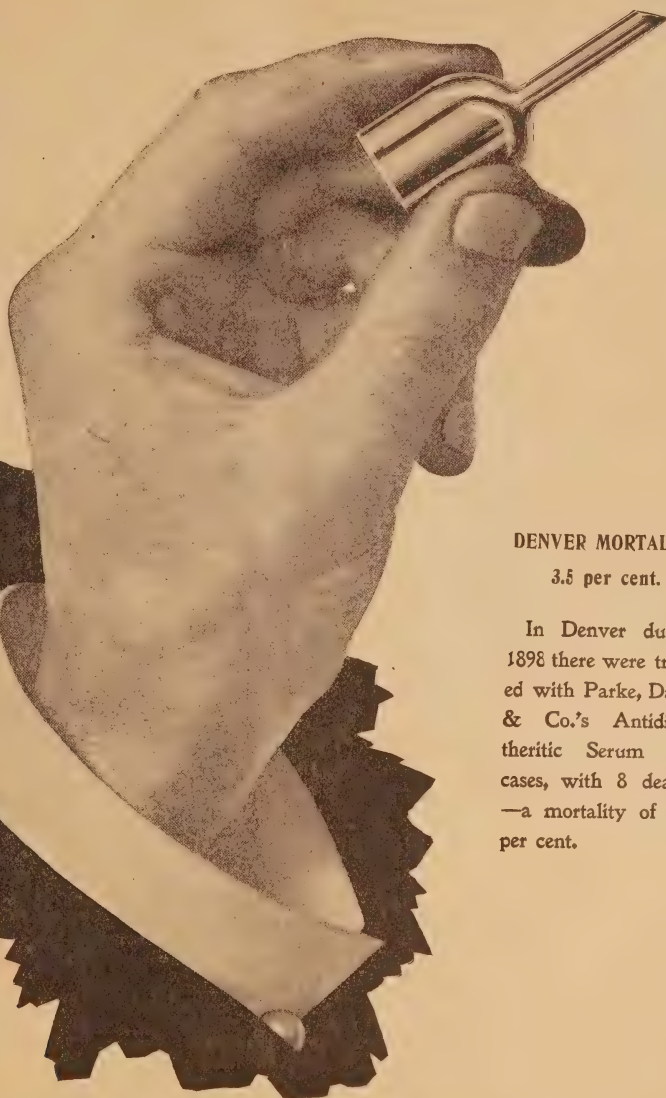
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In Denver during 1898 there were treated with Parke, Davis & Co.'s Antidiphtheritic Serum 230 cases, with 8 deaths—a mortality of 3.5 per cent.

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J. W. CHAMBERS, M. D., Professor of Anatomy.
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EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
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G. MARSHALL SMITH, D. D. S.	Md.		

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L. M. PARSONS, D. D. S.	HARRY E. KELSEY, D. D. S.	C. H. CARSON, D. D. S.
H. H. HAYDEN, M. D., Demonstrator of Anatomy.		
C. F. BLAKE, M. D., Assistant Demonstrator of Anatomy.		

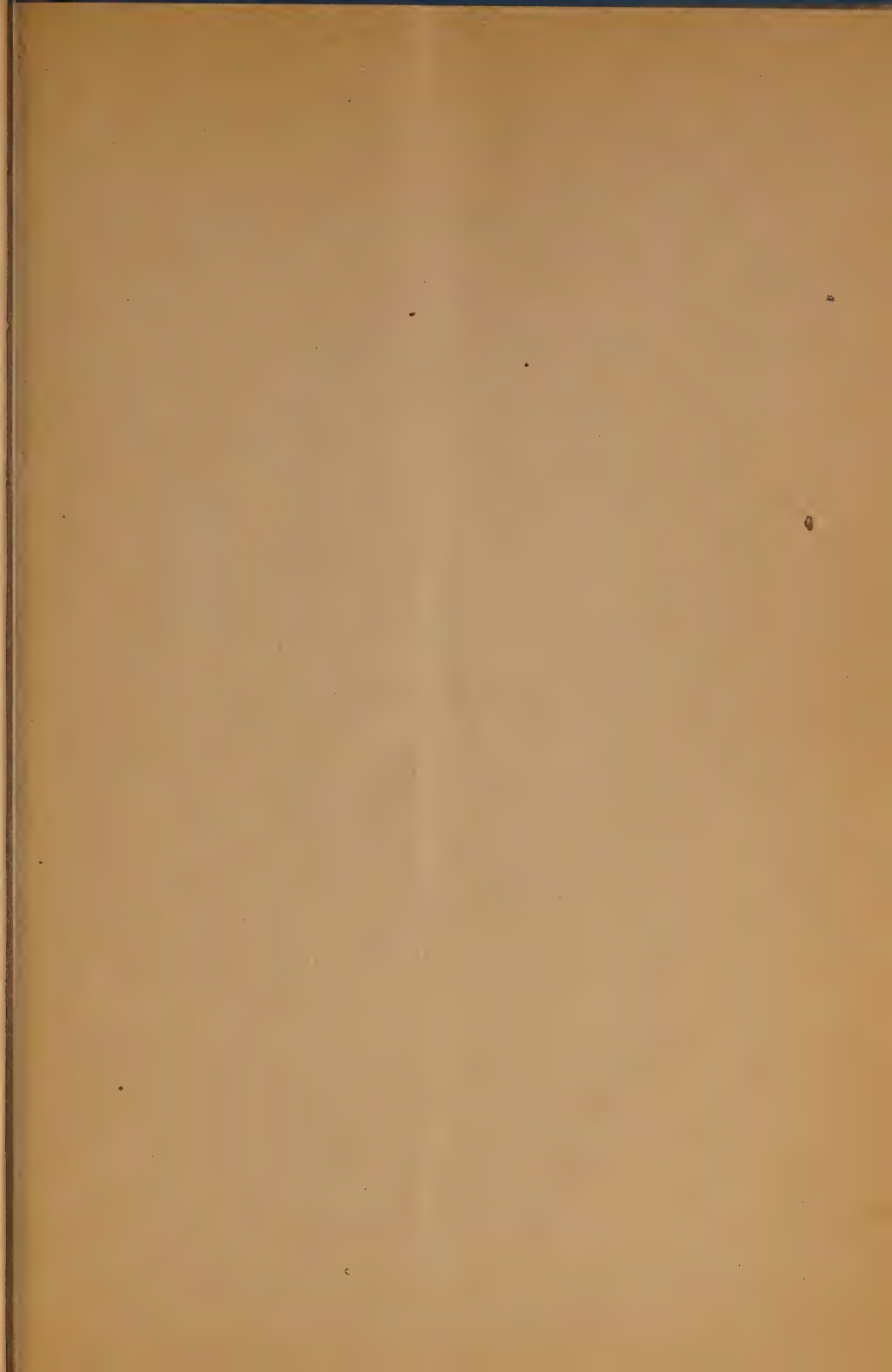
The sixtieth annual session will commence on the 1st of October, 1899, and continue until April, 1900.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD.



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- HARVEY G. BECK, M. D.,
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- MOSES SAVAGE, M. D.,
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Demonstrator of Diseases of Nose, Throat and Chest.

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The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1893, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

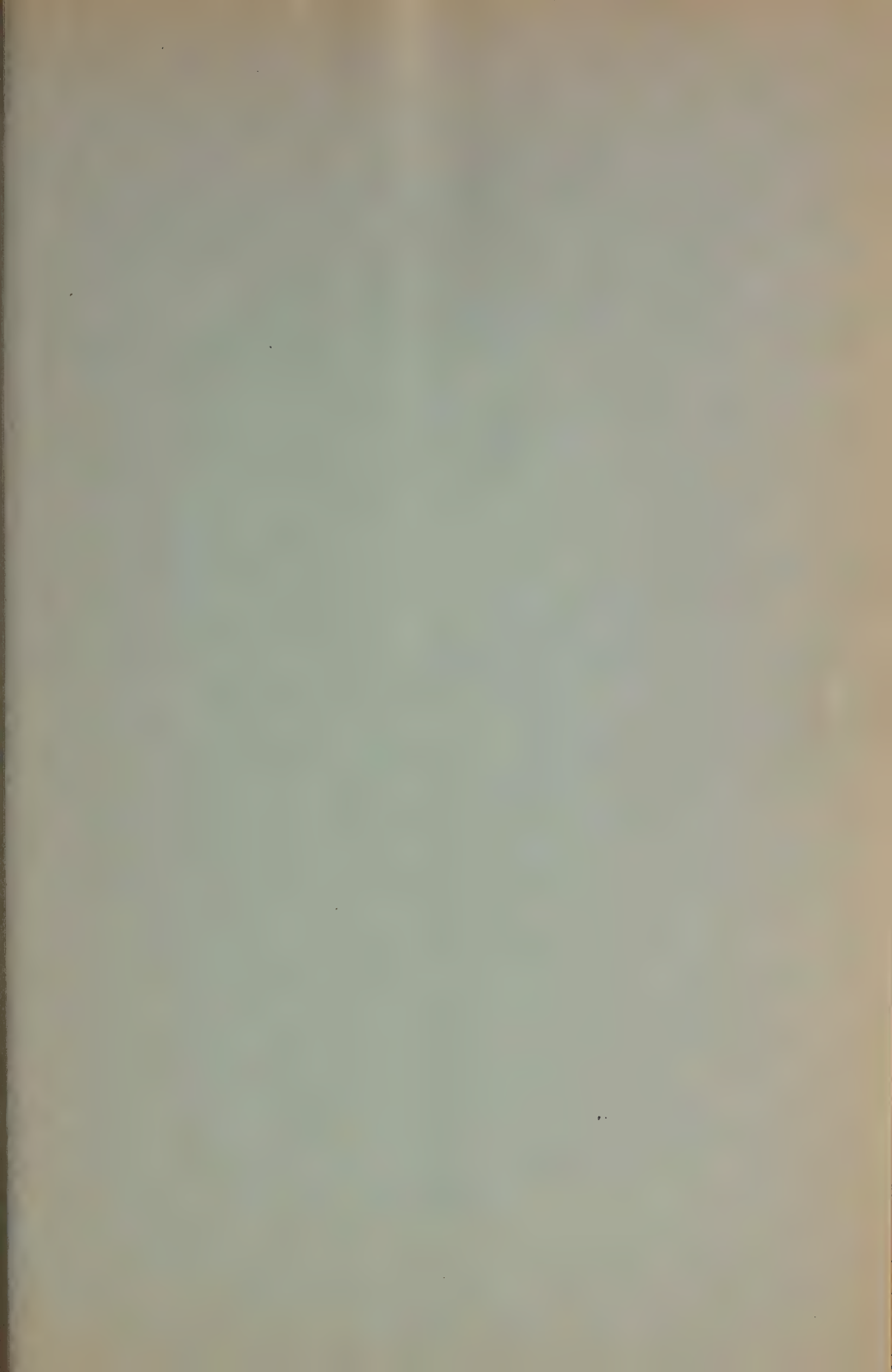
The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

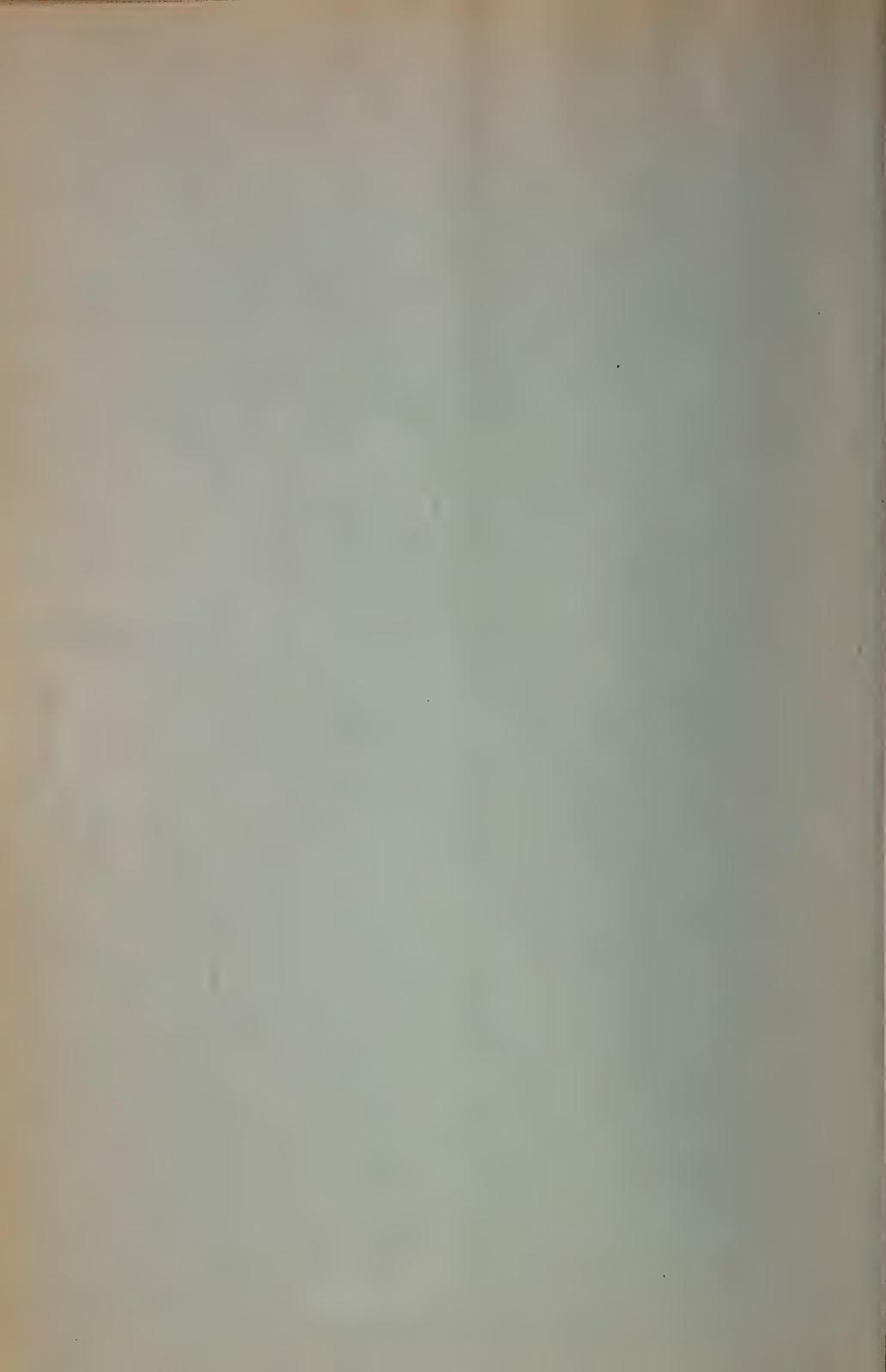
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PROFESSOR THOMAS OPIE, M. D., Dean,

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THE JOURNAL
OF THE
ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS
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BALTIMORE.

Vol. III

No. I

APRIL, 1900

PUBLISHED AT
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Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. M., M. D.

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The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS,

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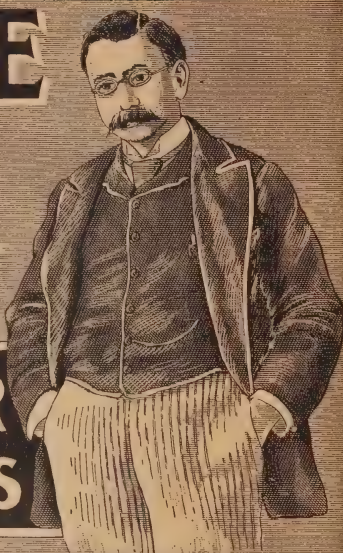
(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

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Personal Notes.

DR. A. A. SWAYZE, '97, has removed from Reading, Pa., to Hackensack, N. J.

DR. T. L. WILSON, '91, is practicing at Bellwood, one of the suburbs of Altoona, Pa.

A CARD.

At the beginning of another season, we beg physicians to consider the advisability of sending more of their patients to us for prescriptions and sick-room supplies. We will waive matters of ethics and base our claims for additional patronage upon the excellent character of our work, the better results secured through concentrated efforts and upon the advantages a comprehensive stock gives us.

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HISTORY OF MEDICINE BEFORE HIPPOCRATES.

BY DR. A. FRIEDENWALD.

The early development of the medical art must have been somewhat similar among all nations. What is considered as medical science among the savage tribes of to-day will serve as a picture of conditions as they existed originally among other people, who gradually advanced to a more or less high civilization. Man at all times when ill or injured sought relief. It appears that at all times, also, there were those who were ready to extend aid, believing or pretending that they knew what would do good in such cases. Remedies were administered, and their effects, if at all conspicuous, could not escape the observation of those who gave them, and for that matter, neither that of those who took them, and so certain remedies gained a permanent reputation. Many remedies given in disease were accorded the merit of curing ills which had run their course—a mistake which bears a very ancient stamp, has had a long and a very extended reign, and from which modern medicine has not entirely been freed. In the early medicine of all nations the supernatural played a prominent rôle. Invoking the gods and evicting devils formed no inconsiderable part of the duties of the ancient physicians. It is very difficult to speak accurately of the very beginning of the treatment of disease

among the ancients, as it is clouded in myths and involved in the most exaggerated superstitions.

In limiting our studies of ancient medicine before Hippocrates we have only to consider the medicine of Egypt, India and Greece. One looks naturally to India, with its early civilization, to contribute a share to these studies, but on account of a faulty chronology there is nothing offered which can be accepted as coming down to us from before the time of Hippocrates.

From the civilization attained by Babylon and Assyria, it is safe to infer that considerable advance was made in medicine. The many cuneiform tablets which are now accessible to Semitic scholars will in all probability furnish interesting revelations in this regard. Dr. Christopher Johnston, of the Semitic department of the Johns Hopkins University has done commendable work in this direction.

In the Healing Art the Egyptians, as in so many other respects typifying her high civilization, greatly outstripped all her contemporaries in the development of the medical and surgical art. The knowledge which has reached us in regard to the ancient Egyptian physician establishes that he also appears in a sacerdotal character. Whether he invariably practised the dual functions of priest and physician has not been clearly ascertained. The skill of the physicians of Egypt has long been inferred from flattering allusions to them by the ancient authors of other nations, among whom Homer, Herodotus and Diodorus Siculus are mentioned. Our principal source of information, however, rests upon the testimony of medical papyri that have been discovered and interpreted in quite recent times.

Notwithstanding the fact that the embalming of the dead was so extensively in vogue, it does not appear that the knowledge of human anatomy was materially advanced thereby. It is claimed that this art was followed as a trade by a distinct class, and that the physicians had no affiliation with the work. This claim has the interest of showing that while everywhere else religious interdictions or strong public sentiment forbade dissections of the human body, and thereby retarded the development of the science of anatomy, that here, where the opening of dead bodies was not regarded as a desecration, the ad-

vantages that might have been derived therefrom seem to have been overlooked. On the other hand, as opposed to the claim that physicians were not engaged in embalming the dead, the passage from the book of Genesis is cited:* "And Joseph commanded his servants, the physicians, to embalm his father; and the physicians embalmed Israel."

Among the papyri alluded to above, the most important, those of Ebers, date from the fifteenth and seventeenth century before the Christian era. It is quite probable that the science as constituted at that time dominated with little alteration for a long time. Diodorus Siculus, who wrote in the century just preceding the present era, says that "All who required medical aid in military marches, as well as those traveling within the limits of the country, received the same gratuitously, for the physicians received a salary from the state. These physicians in the treatment of disease regulated themselves by the prescribed legal directions which had been formulated by numerous and celebrated physicians of olden times. When they, while strictly following the directions laid down in the sacred book, fail to save the patient, they are shielded from all blame; should they, however, have acted contrary to these instructions, they rendered themselves liable to capital punishment, for the lawgiver assumed that only very seldom could a single individual excel the medical art which many years of observation and the most noted masters had established." When this element of restricted individual judgment is taken into account, the high development of the medical art among the ancient Egyptians must appear marvelous to us, and makes evident why they regarded it as of somewhat inspired character.

They were familiar with a large number of drugs, many of which have come down to us, and some still hold a high rank in the *materia medica* of to-day. Among the latter may be mentioned opium, strychnia and squill. There have been a great many prescriptions preserved which show that they availed themselves of a great many drugs, some of not a very æsthetic character, in contemplating which we must bear in mind that it has not been so very long since medicine

* Genesis, chap. 1, v. 2.

of modern times has freed itself from those of a similar character. Some of the remedies employed by them were of a very innocent character; such as honey, which enjoyed an extended use; then oil derived from varied sources; bread in its different states, dough, wheat, dates, figs, onions, garlic, wine, linseed, wax, fennel, peppermint, coriander, juniper, etc. Among a more potent variety we find myrrh, aloes, cloves, soda, various forms of lead and acetate of copper. In another class, employed by them, we find the blood of animals, milk, fat, brain, and to make the assortment complete, the various excreta from the deer, cattle, hog, ass, dog, cat, crocodile, turtle, goose, fish, wasps and other creatures.

The remedies were administered both in the liquid and solid form, and also applied as plasters, poultices, enemas and suppositories injected in the anus and vagina. Solids were employed in the pill and bolus form. The following, taken from the papyrus of Ebers, indicates the wide range which characterized the work of ancient Egyptian medicine. Remedies to facilitate the flow of urine; remedies directed against the voiding of bloody urine, and to destroy worms; remedies for stone and pain in the belly; remedies for inflammation at the anus; for pain in the belly and hips; R. for diseases of the stomach and heart; R. for headache; R. for urinary diseases; R. for glands on the neck, or the abdomen; R. for nausea; R. for diseases of the eye; R. for diseases of the hair; R. for cancer; R. for the healing of wounds, fistulas, ulcers and *aussatz*; R. for erysipelas, itching and the removal of scabs; R. for diseases of the limbs, spinal column, joints, lymphatic glands, tongue; R. for diseases of the skin; R. after cutting out splinters and thorns; R. for diseases of the teeth and parasites; R. for diseases of the nose and diseases of the ear; R. for skin diseases. Then follows a treatise on diseases of women; diseases caused by animals; contributions from the Secret Book of the Physician, concerning the movements of the heart and a description of the heart. The conclusion is derived from a book which bears the date of 3700 B. C., and treats of tumors and pustules.

We find that in regard to surgery very considerable progress was made. Cupping was done by means of horns sawed off near their

point, and general blood-letting was known and employed. Amputations were practised, as is shown by pictures found at Thebes and Denderah. The dental art was not neglected, for artificial teeth have been found in mummies. Decayed teeth were preserved by fillings of gold.

It is quite interesting to learn that in that early time medicine had been divided into specialties, to the extent that there were special physicians for nearly every important organ in the body. When the services of a physician were needed, a messenger was sent to the temple, who would give information as to the trouble from which the patient was suffering, and accordingly, a priest, who at the same time was a physician, was dispatched to the patient.

It is equally interesting to note that medicine had already at that time acquired a sort of international character, for among the many contributors to the work alluded to there appears the name of one Byblos, an oculist, from Phenicia.

According to Brugsh, as cited by Gaslt in his *Geschichte der Chirurgie*, the knife, made of iron, was availed of as early as 1600 B. C. The actual cautery was employed for arrest of hemorrhage, and also for the removal of tumors.

There can be only a very meager account given of the art of medicine among the Jews before Hippocrates. It might naturally be expected with the high development of the art among the Egyptians, with whom they dwelt for over four centuries, that the Jews should have brought with them much of this knowledge to the promised land. Of this, however, there is no evidence. This was probably due to the fact that the practise of medicine was the monopoly of the priesthood in Egypt; and furthermore, that the slavery to which they had so long been subjected precluded the Jews from that intercourse with their masters which might have been to their advantage in this respect. The only references in the Bible to such knowledge are comprised in the embalming of the dead and the art of the apothecary.*

Shiprah and Puah are mentioned as having practised the obstetric art. According to their statement the women did not need their help,

* Exodus, chap. xxx, v. 25 and v. 35.

and their principal merit consisted in preserving the life of the male children against the edict of the king. The more conclusive evidence that the Jews did not acquire much knowledge from the Egyptians in regard to medicine is, that drugs are not mentioned in the Bible, and but very few are referred to in the Talmud, when it is known that the remedies employed by the Egyptians were very numerous.

It is therefore, the more remarkable that at this early period there were such sanitary laws promulgated among the Jews, which have remained a continuous lesson to the world ever since. In the injunctions given in Leviticus, regarding leprosy, we find the three cardinal principals mentioned which regulate the management of contagious disease by the science of to-day, viz., differentiation, isolation and disinfection.

The history of medicine of Greece leads me back to the romance of mythology. Æsculapius was so revered by his contemporaries for his medical skill that he was regarded as something more than human, and it was accepted that he was a son of Apollo. His followers, the Æsculapiades, developed medicine and had schools in which they imparted their knowledge. All the records of medicine up to the time of Hippocrates have been lost, and what is known of physicians before his time is derived from statements made by various historians and poets.

HEADACHE.

By DR. O. S. WOOD, '00.

Headache is a term applied to pain in any part of the anatomical structures situated above the base of the skull. For convenience of description, these structures may be divided as follows: (1) Those outside the cranium, (2) those inside the cranium, and (3) the cranium itself. The extracranial structures may be further divided into the skin, the aponeurosis and the muscles. When we consider the complex anatomy of these structures, the manner in which the nerves and blood-vessels pierce the aponeurosis, the extent of the vascular and nerve supply of the scalp, the wonderful physiological function of the brain, the delicate structure of it and its membranes,

the formation and minute anatomy of the subsidiary cavities of the cranium, it will be readily seen how any one or more of these may be the seat of pain. Headache, excepting one particular form, which will be considered later, is only a symptom, and perhaps no other symptom is so prevalent, or is common to as many different diseases, pathological conditions and impaired functional activities. It will be seen, therefore, that its causes are many, and it will be possible in this connection to consider but a few of the more important ones.

Heredity plays no part in symptomatic headache only so far as the disease or condition which produces it or a predisposition to such disease or condition may be inherited. In a general way age is a factor in the causation of headache. Persons in early adult life, and in middle age, suffer most, but the old and young are by no means exempt. Headache is more prevalent among women than men. Especially is this true during the reproductive period.

One of the most frequent causes of headache among the poorer classes is disorders of the scalp. These disorders are often produced by the pediculi capitis. These parasites manifest a preference for the poorer classes, not alone for the reason that they are uncleanly in their habits, but because they are often poorly nourished and have unhygienic surroundings, which conditions in themselves will produce the symptom. Perhaps the most common cause of severe headache is the different forms of meningitis. It may be tubercular, syphilitic, traumatic or idiopathic; or it may be a slower inflammatory process, which occurs in chronic alcoholism, granular kidney and general paralysis of the insane. The meningitis may also be due to infection from suppuration of the middle ear, or from an abscess in the brain tissue proper. In the acute forms of meningitis the pain is severe. In the more chronic forms it is constant but not so severe.

It may be proper in this connection to mention the old-time question, which has long been argued by physiologists, as to whether the brain itself is devoid of sensibility. It is a well-known fact that gross organic lesions may exist in the brain tissue proper without producing pain. Most notable of these are thrombi and emboli, producing softening and deep-seated abscesses, clots from cerebral hemorrhage

and small tumors. It is not said that these lesions occur constantly without producing pain, but that such may be the case, and when pain is present, either the membranes or the fifth nerve or both are involved in the pathological process. The character of the pain in brain tumor is variable, and rarely does the seat of pain indicate the location of the lesion. It is said, however, that pain in the occiput points to a tumor of the cerebellum, but if a lesion exist at this point it can always be confirmed by other symptoms. The pain may be paroxysmal and at times it is said to assume a regularly intermittent type. It may vary from a slight ache to agony so intense that the cases are not a few in which the patient has chosen death in preference to the penalty nature had put upon him.

The changes in the blood which produce headache will now claim our attention. It is a fact apparent to all that headache and general plethora are often associated. Plethora is a condition natural to some, and it is often increased by nitrogenous diet and sedentary habits. This condition deserves but a passing notice, for blood is more easily spilled than made, and it is a matter of some regret that the physicians of to-day are not so familiar with the relations of the median basilic vein and the use of the history as they were a hundred years ago. By far more important than plethora in this connection is general anemia. The relation of general anemia to headache is one of the oldest established facts in medicine. Hippocrates made the statement that "those who are pale and anemic suffer from headache," and he alluded to the blood as the "moderator of the nerves." The following unique and classical sentence is quoted from Willis: "A long and grievous headache is wont to be cured not so much by remedies applied to or proper for the head, as those which restore the constitution of the nervous juice and blood mass; and such are chalybeates, or steel medicines, and antiscorbutics, or medicines against the scurvy." It is unnecessary to enumerate the various sources of anemia. From whatever cause arising, whether from insufficient food, copious hemorrhage, suppuration, lactation, tuberculosis, malignant disease, the malarial organism, organic lesion of the kidney, liver or suprarenal capsule; or whether it be pernicious anemia, chlorosis

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or leucocythemia, it may occasion the most distressing headache. Such has been said as to the seat of pain in the headache of anemia. No definite conclusion has been reached except in chlorosis, in which frontal headache is the rule. As to the character of the pain, it has been described as "sharp," "shooting," "jumping," "darting," "striking," "knife-like" and "neuralgic." Thus it has been said that "neuralgia is the cry of an impoverished nerve for more and better blood."

Headache may also be caused by toxemia. Poisons introduced into the blood from without, and known as heterogenic, will first be considered. The more important of these are the anæsthetics—alcohol, tobacco and vitiated atmosphere usually due to carbon dioxid. The organic matter exhaled from the human body aids also in poisoning the atmosphere of a poorly ventilated room, as does the burning of gas, as it is said that one gas-jet will consume as much oxygen as four persons. Toxic material in the blood, which is produced within the body, is known as autogenic. That produced in the alimentary canal during the disintegration of the food stuffs is known as the ptomains, and that produced by the vital activities of the tissues is known as leucomains. In health the animal organism is well fortified against these poisons, having the power to render them inert or cast them off, but in certain diseases one or both of these functions may be destroyed and the poisons accumulate in the blood and morbid symptoms result. The ancient writers believed that the urine at certain times and under certain conditions caused headache. Hippocrates wrote: "Those who, during fever, have turbid urine like that of oxen, either have, or will have, headache," and another one of the ancient writers said: "So greatly is the urine agitated in fever that the humors are borne upwards to the sacred domicile of the soul, even as the winds ascend to the heavens, while the base regions below are not freed." It is not for the classical language alone that these sentences have been preserved and handed down through centuries in the medical literature, but for the great underlying truth which they contain, and which is well known to every modern pathologist, namely, the poisonous nature of the urine. The

relation between headache and uremia is now universally recognized, but headache is by no means a constant symptom of nephritis. It is more significant when it occurs in the chronic contracted kidney, and the most careful attention should be given the patient at that time. Next to the diseased kidney in the production of autogenic toxemia is the diseased liver. We have much yet to learn of the physiology of the liver, but enough is known to warrant us in the belief that it has much to do in freeing the blood from poisons. In acute yellow atrophy the nervous symptoms, the chief one of which is headache, are probably due to uremia. In jaundice the headache is due to bile circulating in the blood, as well as the withdrawal of the bile from the intestinal tract, thereby favoring the production of ptomains. It is a well-known fact that an excess of uric acid in the blood is a potent factor in the causation of headache. It is thought to produce its evil effects by its action on the arterioles through the vasomotor system, and migraine, epilepsy and Raynaud's disease are thought by some to be produced in this manner. A proper discussion of this subject involves many details in physiological chemistry. Generally speaking, however, it may be said that the excretion of uric acid is inversely to the acidity of the urine, from which it follows that any substances which diminish the acidity of the urine, such as a vegetable diet, or the alkalies, increase the elimination of uric acid, while those substances which increase the acidity of the urine retard its elimination. The intimate relation existing between the head and stomach through the vagi nerves and sympathetic system has long been known, but whether headache may be produced wholly in this manner is yet somewhat of a question; however this may be, it is well known that any and all forms of indigestion may cause it in a manner which has already been alluded to.

The same question arises in the discussion of the headache which occurs as a result of the diseases of the pelvic organs of the female. Formerly it was supposed that most of the nervous symptoms occurring in these disorders, were produced through the sympathetic and reflex systems. The nervous phenomena occurring at the time of puberty, during the menstrual periods and at the climacteric can not yet be

satisfactorily accounted for in any other way, but we do know that the inflammatory conditions, especially those of a specific nature, produce marked changes in the blood, and that the displacements of the uterus may cause pressure on the rectum, causing constipation, thus favoring the absorption of toxic material from the alimentary canal.

Of the many causes of headache none are more potent and operative than the diseases of the eye, both functional and organic, as well as the so-called eye-strain. Diseases of the nose and throat, including the catarrhal conditions, enlarged tonsils, adenoid and bony growths, are important factors in the production of headache. Diseases of the ear will likewise demand attention, and these together with the diseases of the eye, nose and throat, when once diagnosed or even suspected, should be referred to a competent specialist. Syphilis, tuberculosis and all of the constitutional diseases, together with the acute fevers produce headache, but the manner in which they do it has been discussed.

Formerly headache was considered one of the constant symptoms of insanity, but it is now known that insanity itself is only a symptom and the same cause which produces one produces the other.

Thus, briefly considered, are a few of the more important causes of headache. It now remains to consider that classical form known as migraine or hemicrania, and known to the laity as sick-headache. This distressing condition is characterized by periodical attacks of pain in the head, usually unilateral, accompanied by nausea, eructations of gas, and vomiting. Between the attacks the patient is as a rule free from pain and in ordinary health. Many theories have been advanced as to the cause of migraine. It is thought by some to be almost always due to some error in refraction or accommodation, while others hold that excess of uric acid in the blood is the chief factor in its production. Lately the theory has been advanced that it is one of the functional nervous disturbances, closely allied to epilepsy—a so-called sensory epilepsy. Whatever else may be said of the cause, it is a fact well known to those who have had an opportunity to observe any number of cases, that it occurs in neurotic and tuberculous families, and that a person so afflicted must have inherited a

predisposition to it. The patient is usually advised of an approaching attack by premonitory symptoms. The attack usually begins in the morning, the patient feeling a sense of depression and fullness in the head upon rising. In a few cases, however, the attack is preceded by the opposite condition, and the patient is buoyant and has a tendency to gaiety. As the day advances, pain of a decided character begins to be felt in the head. The special senses become more acute. The temporal artery is swollen on the affected side, and has a feeling of whipcord beneath the skin. Photophobia is present, and the eye on the affected side is retracted, and the lid is partially closed. Toward the close of the day the patient is obliged to refrain from business, and retire to a darkened room. The pain becomes more severe, the uneasiness in the stomach more pronounced and all the symptoms more aggravated until they culminate in the act of vomiting. Severe attacks of vomiting are generally experienced, accompanied by retching, sweating, pallor and extreme prostration, before relief from pain comes. This usually closes the attack and the patient falls into a deep sleep, not unlike that which follows an attack of epilepsy. The frequency of the attacks varies with different individuals; some have them once a week, others once a month, and others less frequently. The treatment of these cases will tax the physician in the extreme. To remove all doubt the patient's eyes should be examined and if errors in refraction are found to exist, the patient should be compelled to wear the proper lenses. Regular habits, a proper amount of outdoor exercise and healthful hygienic surroundings should be advised. Briefly stated, this is what should be done in the interval, but what can we do to relieve the paroxysm? It would appear rational to give a good purge or an emetic or both at the beginning of the prodromal stage. After this has acted, a hot bath, while a cold pack is kept to the head, is advised. If the bath is not convenient, or if its fails to give relief, a hypodermic injection of morphine is the most efficient way to relieve the pain. This latter treatment should be practiced with the utmost precaution, for these patients being naturally of an unstable, nervous organization, are very prone to form the morphine habit, and as this drug affords them relief they will soon learn to rely on it entirely.

The treatment of symptomatic headache is the treatment of its causes, and embraces, as we have seen, almost the entire field of therapeutics. Our first object, then, should be to diagnose the case correctly, that is, to find the cause. If a patient is suffering from a high fever, the cause of the headache is at once apparent to the physician, but in such cases other symptoms predominate and it is the chronic cases as a rule which consult the physician, and it is these which will test our skill. When a patient presents himself, the physician should first make inquiry as to his past history, both family and personal, his mode of life, occupation and every detail bearing on his present condition. He should then make a careful physical examination from head to foot, and then an examination of the urine and blood; and also the sputa if tuberculosis is suspected. Once finding the cause, the battle is half won. There are not a few cases, however, which suffer from headache in which the cause can not be ascertained, even after such an examination as has been indicated. Proper diet and regular habits as to eating and sleeping should be enjoined. Of all therapeutic agents, none is more beneficial in a general way than outdoor exercise. The failure to observe this has caused untold suffering, and has aided in infecting one-fourth of the entire human race with tuberculosis. Hot and cold applications, counter irritation, dry cupping, local anodynes, electricity, bleeding, pressure applied to the head, and compression of the cerebral vessels, may each be valuable in certain cases. The drugs which have been used in the treatment of headache compare in numbers with the causes which produce it. Some of them have been used rationally, having a chemical action on the poisonous material in the blood, while many of them have been used in an empirical way. In recent years the coal-tar derivatives have become popular in this way, the most efficient one of which is phenacetin. In aggravated cases, other remedies failing, the opiates will have to be resorted to. Finally, let us remember that time-honored admonition, which is as old as medicine itself, and which applies alike to physician and patient: "Keep the feet warm, head cool, and bowels open."

THE TREATMENT OF SYPHILIS BY THE GENERAL PRACTITIONER.

BY DR. HARVEY P. JACK, '91.

Continued from Vol. II, No. 4.

Some chancres require stimulation. Nitrate of silver, 30 grains to the ounce of distilled water is valuable. Black wash is a good dressing for the deeply ulcerating indolent Hunterian chancre after cleansing and touching it over with tr. ferri chloridum. It is said to be a clinical fact that ointments heal indolent sores on the body of the penis, and liquids those on the glands when they are indolent.

A married man who has contracted this disease should refrain from intercourse for at least two years, and even then there is danger of infection.

While treating locally the chancre, the preparatory treatment for syphilis should be conducted. He should visit a dentist and have his teeth and mouth put in the best possible condition. His skin should be kept active by baths and massage. He should go to bed early and sleep late; his digestion and assimilation should be put in the best possible condition and a hematic tonic given of iron, arsenic, quinine and strychnine, or the syr. hypophos. comp. He should exercise moderately and keep his mind as pleasantly occupied as possible. His habits regulated as to the use of alcohol and tobacco, although neither is harmful in moderation, but in excess the former is suicidal. Tobacco is contraindicated only when mucous patches are present.

At once, on the appearance of the eruption, the administration of mercury in one of its forms and according to some one of the systematic methods hereafter outlined is to be begun thoroughly, for it is in the early months that we break the back of syphilis.

The bacterial origin of syphilis is now generally believed, and also that mercury kills the micro-organism. Experience has demonstrated that the grave forms of syphilis of the bones or viscera or nervous system developing after a mild, early outbreak are in the vast majority of cases due to inefficient treatment or where the medical attendant,

fooled by the innocent manifestations of the disease, has failed to administer mercury in sufficient doses and for a sufficient time.

The preparations of mercury chiefly used are (1) the proto-iodide, (2) the tannate, both of them excellent preparations, (3) calomel, (4) bichloride, (5) hydrarg. cum creta, Hutchinson's favorite preparation, (6) the biniodide, very useful when yellow iodide disagrees. There are several different methods of administering mercury, but most writers are agreed that it should be administered in half the full dose the patient can stand without ptyalism, for two and one-half years with short intervals of rest, during which inunctions or hypodermic injections should be used. Hypodermic injections alone form the favorite method of some, but relapses occur and sooner or later other methods have to be adopted and continued for the full time, so that most writers have placed the hypodermic use of mercury in the emergency methods or when the rest is taking place from mouth medication. Of the various methods of administering mercury I shall describe only those which have stood the test of experience and meet general approval among specialists.

(1) Systematic method, (2) continuous method, (3) inunction method. In all methods of administering mercury the first thing to do is to choose your preparation. The proto-iodide is the one generally used internally, but frequently patients will be found unable to take a sufficient dose of this to act on the symptoms without constant gastro-intestinal irritation; then some other preparations must be adopted.

1. The systematic method. In this method a rest is given the intestinal tract at intervals of three or four months, during which the patient is to use inunctions for two weeks. In this method the patient starts with one-half grain doses of proto-iodide of mercury three times daily to be increased by one dose every day until the susceptibility of the patient is ascertained. The condition of the mouth is the guide. The colic and diarrhœa indicate the condition of the intestinal tract. If diarrhœa becomes troublesome before the symptoms of ptyalism or we have touched the gums, mercury with chalk is chosen and pushed until the gums are tender and the saliva begins

to become thick and glairy and the teeth are tender on closing them sharply; this is a valuable guide and one I constantly use. Should this preparation disagree another is chosen, the bichloride or tannate and pushed as before. If, as is rarely the case, none can be borne to this point, inunctions are used. Opium is not advised for fear of the habit. After this point has been reached the mercurial is dropped one-quarter, and later one-half in dose and continued for three months and then stopped and inunction of blue ointment given for two weeks. This is kept up for two years then patient put on KI for six months. It is stopped for two reasons; to give the stomach a rest and to prevent toleration. Should bad symptoms occur, the remedy is pushed again to the point of ptialism. If this fails to control the symptoms, inunctions are given, failing then, hypodermic injections of mercury are resorted to.

This is one of the surest and best methods of curing syphilis. The objection to it is the difficulty oftentimes of getting the patient to consent to the inunctions.

Prof. Gross used to meet all objections to inunction treatment by having his patients, after using a hot foot-bath, rub into alternately one foot and then the other one-half dram of mercury oleate each night, until the effect was produced. Each time after anointing the foot thoroughly, covering it with a woolen sock to be worn 24 hours. However, when the conditions are urgent as in iritis or ulceration of the palate, hypodermic injections or more extensive inunction will need to be resorted to. In following out this method, following Taylor, I have combined iron always with the proto-iodide as in the following prescription:

R Hydrarg. Proto-iodidi gr. $\frac{1}{2}$ to $\frac{3}{4}$.
 Quin. et Ferri Cit. gr. 5.
 Ext. Hyoscyamus gr. $\frac{1}{8}$.
 Opii pulv. gr. $\frac{1}{8}$.

M. ft. pil. no. 1. Sig. One t. i. d. 20 minutes after food.

A mouth wash containing potassium chlorate should be used daily and a warm bath should be taken three times weekly, and for alopecia,

if any exist, a prescription like the following will be found exceedingly useful:

R Hydrarg. Bichloridi.
Resorcin.
Tr. Cantharis.
Spts. Myrciae.

Misce et sig. Use as directed.

Shampoo the head thoroughly three times daily. New hair will grow in rapidly. A Turkish bath is very useful in following out this method of treatment as often as once a week, or at most, two weeks. Horwitz has modified this method by giving hypodermic injections in place of the inunctions. Tonics will often be necessary. The syr. hypophos. comp. is one of the best to give in addition to the mercury. Potassium iodid is often indicated in the early syphilis as is mercury in late. It should always be used in conjunction with mercury in good doses, 10 to 15 grains if ulcerous lesions are present.

Conditions of periostitis and severe neuralgic pains, and where mercury is not well borne, call for its use. Fournier claims greater benefit from bichloride in the latter part of the course of treatment. This systematic method, originated by the distinguished Prof. White, is the treatment *par excellence* of the last two groups of cases in our classification, including the two forms of malignant syphilis, or in any case where syphilis is severe, has high fever, severe pains in the bones, general adenitis, and the appearance of several kinds of eruption at the same time, such as widespread roseola, vesicular or crustaceous eruptions, mucous patches or alopecia, indicating the absorption of a large amount of poison.

2. The continuous method of treatment, or Keyes' tonic method will now be described. This treatment of the distinguished Keyes is applicable to the first two groups, benignant and benign syphilis. It has the great advantage of doing away with constant puttering at physicians' offices every week or two for change of prescription, and consequently is much more likely to be followed out more carefully to the very end, and therefore to give the best results. The preparation is chosen as in the method just detailed. Always given in

recognized fractional doses; bichloride, 1-10 gr.; blue mass, 1 gr.; proto-iodide, 1-5 gr.; proto-iodide preferred. The remedy is then pushed to the limit. Keyes says: "Occasional pain I pay no attention to; free movements I do not regard unless watery; mild colicky diarrhoea is what I wait for, and when this comes I write down the number of pills necessary to produce it, and name this the *full dose*." The dose is then cut in two and, if no untoward symptoms present themselves, is continued for two years. In the event of rebellious symptoms, return to the full dose is commenced, and failing then, inunctions or hypodermic injections of 1-6 gr. mercury bichloride. Opium is given in small doses if diarrhoea is present after the proper dose has been determined, but this is not often needed. This method of treatment is applicable to cases in the first two groups, the vast majority of the cases of syphilis, benignant and benign. Change of climate is of great benefit in either method. I can now recall a case of severe syphilis which I treated by White's method, and which did not do well for a year in spite of all efforts, but immediately upon a change of climate for two months, returned in brilliant health. I have used both these methods of treating syphilis in some twenty cases; ten for four years, and I believe as almost all writers tell us, that they represent the very best, in fact, the only practicable methods of treating syphilis successfully. Three of these were very severe cases, but ultimately recovered under the full systematic course.

Gummatous syphilis demands the free use of potassium iodid. Most cases will be controlled by the time 60 drops of the saturated solution has been reached. Others require much larger doses, and inunctions at the same time. Wm. P. Porter, of New York, limits the diet in his cases to milk after cleaning out the intestinal tract with a few large doses of calomel.

He administers the ox-gall compound pill to digest the milk three times daily, and gives internally the following prescription:

R	Hydrarg. Biniodidi.....	gr. 1½.
	Pot. Iodid	drams 2.
	Ammon. Iodid.....	drams 6.
	Tr. Gent. Comp.....	q. s. ad ounces 3.

M. et sig. teaspoonful three times daily.

Increase if no results. This treatment, so briefly outlined, is very valuable. I have used it in one case, a severe hemiplegia; in a case which was untreated and undiagnosed for two years. The result was excellent and restored a paralyzed idiot to fair usefulness and capability.

Prof. Porter claims better results from this combination of iodide and mercury. Some cases should be sent to the Hot Springs when all else has failed; these are rare cases, but they exist, says Keyes. No benefit is ascribed to the water except the peculiarity of its heat, which enables cases, who could not otherwise, when taking the baths to take enormous doses of the specifics. Nor can they take these doses by any other system of bath as Keyes has demonstrated.

In malignant syphilis, after the course of treatment is over, a reconstructive tonic of:

R	Gold and Sodium Chlorid.....	gr. $\frac{1}{10}$.
	Acid Arsenious.....	gr. $\frac{1}{40}$.
	Zinc Phosphate.....	gr. $\frac{1}{10}$.
	Strychnine Sulph.....	gr. $\frac{1}{30}$.

Ft. pil. no. 1

should be prescribed and continued for some time without the arsenic; after a while mercury should be continued for some time after the disappearance of the gumma to prevent a relapse. The use of serum from secondary syphilitics is undergoing a trial as is animal serum in injections, from animals immuned to syphilis. (So far the results have been negative.) Let us hope that the future will disclose some usefulness in this method.

I have attempted to sketch the outline of the latest and most approved methods of treating this disease, and to sum up the best methods as related to the cases seen by the general practitioner, as well as to show why we should be very urgent and earnest in our efforts to educate our patients up to the required standard in this respect.

However imperfectly this has been accomplished, the effort has been sincere, and if I have been successful in convincing one man, that the one effort he shall make in the one case he may see, will be one thorough one to treat the case up to the highest standard, I shall feel more than repaid.

HYSTERICAL BLINDNESS, WITH REPORT OF CASE.

BY DR. GEO. S. McREYNOLDS, '98.

The following case came under my observation while on the house staff of the Baltimore City Hospital:

J. D.; aged 35 yrs.; American; widower.

Family History.—Mother died with cancer of stomach. Father died with pneumonia. Twin brother alive and in good health. Has three children, all in good health.

Previous History.—Had gonorrhea 15 years ago. Claims to have had no sore on penis, but did have double bubo at time of gonorrhea. Has not had any skin eruption at any time. Is of neurotic temperament. About two years ago, after being exposed to sudden changes of temperature, had severe headaches. These headaches persisted. About 6 months after this was under treatment in one of the hospitals of this city, and thinks he was given pot. iodide, gr. xxx t. i. d. Five weeks of this treatment entirely relieved him of his headaches, and he left hospital and discontinued all treatment.

About Feb., '98, headaches recurred, when he returned to same hospital and was again put on pot. iodide, and mercurial inunctions were added. At expiration of six weeks the headaches were relieved.

Aug. 18. Headaches returned again.

Aug. 19, 1898, was admitted to City Hospital about 3 P. M., complaining of severe headaches. He was put to bed and went to sleep. He awoke about 6 P. M. and found that he was totally blind in both eyes, not even having light perception; pupils react to light, but left pupil sluggish. He was ophthalmoscoped about 9 P. M. by Dr. H. Friedenwald and myself, but nothing could be made out more than some slight congestion of fundus, which was slightly woolly, but was easily within bounds of normal. The same condition in each eye. He was given pot. iodide gr. xxx t. i. d. and purged freely.

Aug. 20. Can now see a little at dusk. Headache still very severe.

Aug. 21. Slightly improved, but still can not see in daytime.

Aug. 22. Can now see a little in daytime.

Aug. 23. Vision very much improved.

Aug. 30. Vision normal. No headaches, and patient left hospital with positive instructions to keep up pot. iodide.

Feb. 25, 1899. Patient returned to City Hospital, and says he kept up pot. iodide about 3 weeks.

Since Feb. 1, 1899, has been having headaches, which have increased in severity.

On morning of admission, Feb. 25, 1899, left eye became totally blind. Right eye, vision unimpaired. Has very severe headaches. Pot. iodide again given, gr. xxx t. i. d.

Feb. 26. Dr. A. Friedenwald and myself ophthalmoscoped patient, but found no deviation from normal other than previously observed. The two eyes looked the same. Left eye still blind and can only count fingers at two feet with right eye.

Feb. 27. Vision of right eye very much improved. Left eye still blind.

Feb. 28. Increased pot. iodide to gr. xxxx t. i. d. Vision of right eye good. Left eye begins to see light.

March 1. Vision right eye about normal. Left eye counts fingers at 6 feet.

March 2. Has reading vision in each eye. No headaches.

March 6. Discharged in very good condition.

May 4, 1899. Patient again appeared on the scene; complains of headaches for several days and again has failing vision of left eye, 20/40. Good vision in right eye, 20/20. Patient then had a +1D.S. and a -1D.S. placed before left eye, which brought vision from 20/40 to 20/20, or normal. I have not seen patient since last-named date. General physical examination of patient was made, but no abnormalities could be found. Urine normal.

In reporting this case it is not with the idea that I am giving anything new, but that it is a comparatively rare occurrence, and that each case of its kind may show some unusual point. I do not wish to go on record as pronouncing it as positively a case of hysteria, but the mode of appearance of the attacks, and also their rapid disappearance, the absence of light perception, the absence of any discoverable lesion

in the eyes, the neurotic temperament of the patient, and the marked improvement of vision with neutralized lenses, all point very markedly to this diagnosis. Of course, we should consider the possibility of an intercranial tumor, and that the patient improved under the use of pot. iodide, but I know of no tumor of sufficient size to cause complete blindness and to disappear entirely in six days. Also, had it been an intracranial tumor that would cause complete blindness, we would have a right to expect some changes of fundus. Neither would the effects of a tumor be dispelled with neutralizing lenses. The only other thing that would occur to us would be malingering. But this, I am quite positive, was not the case. Judging from his actions at the time of attacks, it was certainly as genuine a case of blindness, as far as the patient was concerned at the time, as I have ever seen.

I regret to say that patient's fields of vision were not taken, which might aid us materially in the diagnosis.

Jany. 10, 1900. Patient has just been to see me, and reports that during Sept., '99, he had another attack, his left eye becoming entirely blind and right-eye vision very much diminished.

The absolute blindness of left eye lasted five days when it rapidly improved and was entirely relieved in two weeks. In the mean time right eye had recovered.

Have gone over his vision to-day and find that it is 20/20 when all error of refraction is corrected.

He was also ophthalmoscoped to-day and condition of fundus was identical with the condition of fundus when he did not have light perception.

January 12, 1900. Patient came to me again complaining of very poor vision in left eye. Examination showed fingers at 3 feet with left eye. Right-eye vision 20/30. Field, right eye, almost exact counterpart of normal field as far as shape is concerned, but 18° was the farthest out he could go on temporal side, and on inferior nasal side it went into 12° . Left-eye field about 8° in all directions.

Fundus in each eye shows same appearance it did two days previous when vision was about normal. Pupils active. Given syrup iodid

iron grs. x., t. i. d. This was used as it came nearer the taste of Kd. which he had always been given before.

January 13. Right eye failing. Left eye, cannot count fingers or even see light.

January 15. Thinks right eye has improved. Left eye cannot see objects.

This afternoon, with Dr. Harlan, we tried him by placing a red glass over right eye and nothing over left eye and he was able to read letters of complementary color. Then we tried placing a strong x. glass, 10° , before right eye and he was able to read 20/30. He was then shown that he was seeing with left eye, very much to his surprise and delight. He left hospital next day, but still having severe headaches.

I now feel that I am justified in saying that this is a case of hysteria and nothing else. Those who have not seen the case might insist that it was malingering, but any one who has seen him during an attack would not make such a false charge.

GLYCOSURIA IN DIPHTHERIA.

Dr. Michael J. Morrissey, '97, working with the late Dr. Cleon Melville Hibbard, at the Boston City Hospital, has made some extensive observations in reference to the presence of glycosuria in diphtheria. The following table and conclusions give a synopsis of the results of their observations:

In the following analyses only those cases that gave a positive result both by Fehling's and by the phenylhydrazin tests were considered as instances of glycosuria. Doubtless many of the urines, not in the table, which reduced the copper solution, contained glucose, but for various reasons the phenylhydrazin test was not applied to some of them.

Table I gives the results of Fehling's tests in 230 cases of diphtheria, in all of which the Klebs-Loeffler bacillus was found. Some

of these patients were well along in convalescence; other urines were examined only once or twice. The cases are classified according to the presence or absence of pseudomembrane and its location.

TABLE I.—RESULTS OF FEHLING'S TEST.

	RECOVERED.			DIED.			TOTAL.		
	No. of cases.	No. of positive reactions.	Percentage of positive reactions.	No. of cases.	No. of positive reactions.	Percentage of positive reactions.	No. of cases.	No. of positive reactions.	Percentage of positive reactions.
No membrane	22	0	0	1	0	0	23	0	0
Membrane on tonsils..	98	8	8	3	1	33	101	9	9
In nose	5	2	40	0	0	..	5	2	40
In larynx	11	2	19	2	2	100	13	4	31
Tonsils and nose.....	45	12	27	6	5	83	51	17	33
Tonsils and larynx....	19	10	53	5	4	80	24	14	58
Nose and larynx.....	5	3	60	1	1	100	6	4	67
Tonsils, nose and larynx	3	2	66	4	4	100	7	6	86
Total	208	39	19	22	17	77	230	56	25

It is seen that in the cases without false membrane there was no positive reaction, and that, in general, the more extensive the membrane, the more frequently a positive reaction was found. A reaction was noted in 19 per cent of the recoveries, in 77 per cent of the fatal cases and in 25 per cent of all the cases.

CONCLUSIONS.

(1) There is a transitory glycosuria in diphtheria, which is found frequently in the severe cases and is usually present in the fatal ones.

(2) This glycosuria is often associated with albuminuria.

(3) Injections of diphtheria antitoxin are occasionally followed for a few days by a slight glycosuria.—*From the Journal of Experimental Medicine.*

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THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

ANNOUNCEMENTS.

Monday April 23. Annual Alumni Meeting, College Building, 8 P. M. Annual address by Dr. Wm. F. Smith. Immediately after the address a smoker will be given to which all Alumni and students are invited.

Tuesday April 24. Commencement, Ford's Opera House, 12 M., Rev. C. Ernest Smith, orator.

MEETING OF THE ALUMNI ASSOCIATION.

A special meeting of the Alumni Association was held at the College building on the evening of February 21st. The feature of the evening was an illustrated lecture by Dr. Lewellys F. Barker of the Johns Hopkins University.

Dr. Barker described and showed photographs taken in Japan, where he stopped for about ten days; Hong Kong and Canton, where only short stops were made; and Manila and the surrounding country, where the greater part of the time was spent. From Manila Dr. Barker went to the plague districts of India. One hospital which he visited had over eight hundred patients in it suffering from the

bubonic plague, and had only one physician and he was on crutches. Every eight minutes a new patient was brought into the hospital and every ten minutes one was carried out dead. The nursing was done by members of the family of the patient. The greatest difficulty of the surgeon in charge at the time of the visit was in securing grave-diggers and people to do the ordinary washing. In the morning a crew of natives would be started on this work, but if one of them took sick the whole crowd would leave.

The whole lecture was most excellently illustrated and abounded in valuable and interesting information put into that clear and fluent English which only those who have heard Dr. Barker can fully appreciate.

After the lecture a light lunch was served and Dr. Brack and his company of entertainers (all students) amused the assembly the remainder of the evening.

The meeting was the most successful that the Association has ever held.

THE COLLEGE MEDICAL SOCIETY.

Saturday evening, March 17th, the last meeting, for this College year, of the Students' Medical Society was held. The work of the Society during the year has been excellent. Nearly all the papers presented have been cases reported by the students, the members of the Faculty taking only a minor part. The program of the last meeting was considerably out of the usual order. Dr. Simon explained and demonstrated the method of sending messages by wireless telegraphy. Dr. Preston gave an outline of the history and present status of hypnotism, with a demonstration.

All of the students and many alumni were present.

The value of the work done in this society will become more apparent as the years go by. Those present not only learn some definite facts in medicine and surgery, but those taking part are making an excellent start in work that will give them influence in medical circles after they have graduated.

Personal Notes.

DR. A. J. WOOFER, '82, is located at Troy, W. Va.

DR. M. L. CURRIE, '88, has recently located in Savannah, Ga., where his prospects are very good.

DR. ARTHUR HAWKINS, '95, since leaving Spring Grove Asylum, has located at Mt. Savage, Md.

DR. W. J. VESTAL, '83, is reported to be making a great deal of money from his practice at Tyro Shops, N. C.

DR. RIED HUNT, '96, is Associate in Pharmacology in the Medical Department of the Johns Hopkins University.

DR. PAUL COLSON PERRY, '97, was married to Miss Charlotte Marion Bowden at Jacksonville, Fla., February 14, 1900.

DR. DAVID J. HILL, '93, is now in Baltimore doing post-graduate work. He is in practice with his brother, DR. JOEL HILL, '80, at Lexington, N. C.

DR. W. E. TURLINGTON, '82, died recently at Benson, N. C., of cerebral hemorrhage. His brother Dr. W. T. Turlington, '94, is practicing at Fremont, N. C.

DR. J. M. LOWREY, '97, who has been the resident physician at the Hebrew Hospital, has been appointed an Assistant Surgeon in the Army and ordered to Manila.

DR. HARRY VAUGHN, '95, of Morristown, N. J., writes: "I am practising in a city of 12,000, twenty-eight miles from New York. Near by is the State Hospital for the Insane under the supervision of DR. B. D. EVANS, '85."

DR. GEO. S. McREYNOLDS, '98, is mentioned in the annual report of the Presbyterian Eye and Ear Hospital in this flattering manner: "Our Resident Physician, Dr. McReynolds, has been untiring in his efforts to give the Hospital good service, and has been largely instrumental in its successful administration." He will locate in Memphis, Tenn., and devote himself to the treatment of diseases of the eye, ear, nose and throat.

DR. JOHN C. MORFIT, '96, was operated upon recently for appendicitis. The following account is from "The Sun": "Dr. J. C. Morfit, of 3533 Olive street, one of the most highly qualified surgeons in this city, was suddenly taken with appendicitis on last Wednesday afternoon. In the evening he sent for some physicians and asked them to make an examination. It was determined that Dr. Morfit most probably had appendicitis. Dr. Morfit said he was ready to be operated on, but the operation was not decided upon just then. By 4 o'clock the next afternoon the patient had determined for himself that he wanted his abdomen cut open and the offensive or diseased intestine removed. Without the slightest hesitation he went to the Baptist Sanitarium and prepared to be operated on. He got upon the table and inhaled the chloroform, and during the twenty minutes occupied by the operation was sound asleep. The first thing when he awoke was to ask to see his appendix. He is resting easily, and his physicians think he will make a speedy recovery. The operation was performed by Dr. A. C. Bernays, who was assisted by Dr. John Young Brown and Dr. Spencer Graves. Drs. Edwin Kurtzeborn, Jack Howell and Cowen also aided their colleague."

POUGHKEEPSIE, October 17th, 1899.

DR. WM. S. GARDNER.

Dear Doctor.—Enclosed please find \$1.00 for JOURNAL. The JOURNAL should be supported by all the Alumni and is only a case of procrastination on my part for not sending in my subscription before.

I have been here in this city of 25,000 since April 5th, 1898, where

there are about forty doctors. Have had my share of business and perhaps a little more.

I am City Almshouse Physician, Visiting Physician to Old Ladies' Home, Surgeon for the City Electric Railroad and Examiner for the Prudential and Vermont Life Ins. Companies.

I often think of the time spent at the College of Physicians and Surgeons with great pleasure.

With kindest regards to my professors and friends, I remain,
Very sincerely,

FRED T. LAPE, '96.

YORK, PA., March 1st, 1900.

Dear Dr. Gardner, Editor.—You will find enclosed \$1.00 for the JOURNAL OF THE ALUMNI ASSOCIATION beginning with January 1st, 1900. Send me all back numbers of this year, please. I can't do without the JOURNAL. You will notice that I am no longer at my old post in Manheim. I sold out to Dr. L. E. Wolfe, class '91, who is abundantly able to carry on the unfinished work satisfactorily.

I have lived in this beautiful, energetic city four months and am happy to say that I am well satisfied with my choice. This being my native county, I find many faces, from time to time, whom I knew well in days of yore. This gives me very great pleasure indeed. People and brother physicians treat me so well that I feel as though I should like to remain here always.

My work is very congenial to what is left of my racked corporation after 22 years climbing the hills and dales and broad plains (in snow-storms, too) of Lancaster County, the garden of Penna.

Come and see me and bring my much-loved Faculty and members of the Alumni with you. How many of our boys are practising here, I wonder?

With kindest regards and best wishes, I am,
Yours fraternally,

J. H. SIELING.

PLYMOUTH, PA., February 26th, 1900.

DR. WM. S. GARDNER, Baltimore, Md.

Dear Doctor.—Yours of 23d in reference to the Alumni to hand, and in reply would say that unfortunately I know the address of very few. My brother, Dr. Dan. G. Beckwith, '93, did well as to number of patients while in Scranton, in fact, worked himself to death. On the 15th of January, 1898, he made 69 professional visits, was feeling as well as usual, and at 10.30 p. m., two miles from his office, the poor boy dropped dead while stooping to examine a little patient. I took him to our old home in North Carolina for burial.

I have seen few men in my life who were more popular among his patients.

Wishing the JOURNAL much success, I am,

Yours sincerely,

J. F. BECKWITH, '81.

FEDERALSBURG, MD., January 24th, 1900.

DR. W. S. GARDNER.

My dear Doctor.—Allow me to bother you for a few minutes. Accept my thanks for JOURNAL in the past and enclosed find check \$1.00 for same in future. Were it not for the greatly regretted death of Dr. Rohé I should ask you to publish the song sung by Zemp of N. C. at the '94 banquet. I believe you were joint perpetrator of that festive lyric. As you have probably forgotten me anyway, it is not necessary that I should tell you the story of my life. Have had the usual P. & S. luck—not much money but plenty of experience medically and otherwise—mostly otherwise.

Have not had as yet a chance to view the improvements, but the Faculty need not be bashful about using same on that account. I trust I may soon have an opportunity to drop in and see Chambers open about three yards of intestine, rake it off with a Simon's spoon, wrap it up in a bundle of jokes and return it to its proper place as in the merry days of yore.

With best wishes for yourself and the JOURNAL staff, I am,

Yours fraternally,

GEO. F. GALLOWAY, '94.

STEPHENS CITY, VA., March 12, 1900.

WM. S. GARDNER, M. D., 1012 McCulloh Street.

Dear Doctor.—Please find enclosed my check for the payment of one subscription to the JOURNAL of the Alumni Association; date it as far back as you please, as I fully intended subscribing a year ago.

I hope it will be my pleasure to meet with you at your next annual meeting, and would love to meet all or as many as possible of the class of 1897 there. My success since graduation is phenomenal. I hold four positions as medical examiner and medical attendant, in as many public trusts. Please address

S. M. STICKLEY, '97.

JACOBUS, PA., February 28, 1900.

Dear Doctor Gardner.—It seems to me that my subscription to our valuable Alumni JOURNAL has not been paid for some time, hence the enclosed check for \$2.00. Having heard of the modesty that envelops many physicians relative to the presentation of bills, and thinking that the esteemed editor of our JOURNAL may be similarly affected, I take this opportunity of "passing in my check."

The Goddess of Fortune is still with us, and we are doing a successful general practice at the old stand.

Have just completed a term as first vice-president of the York County Medical Society, a society consisting of nearly 90 members.

I hear from Warwick occasionally; he is happy as ever—getting on well.

Fraternally yours,

F. J. SNYDER,

Class '87.

BEDFORD CITY, VA., Oct. 17th, 1899.

W. S. GARDNER, M. D., 1012 McCulloh St., Baltimore, Md.

My Dear Doctor.—Some time back Dr. H. Friedenwald informed me I had been chosen, selected or elected, I forget which, to act as president of the College Alumni for the State of Virginia. Why I was so honored I know not; I wrote to the doctor acknowledging his

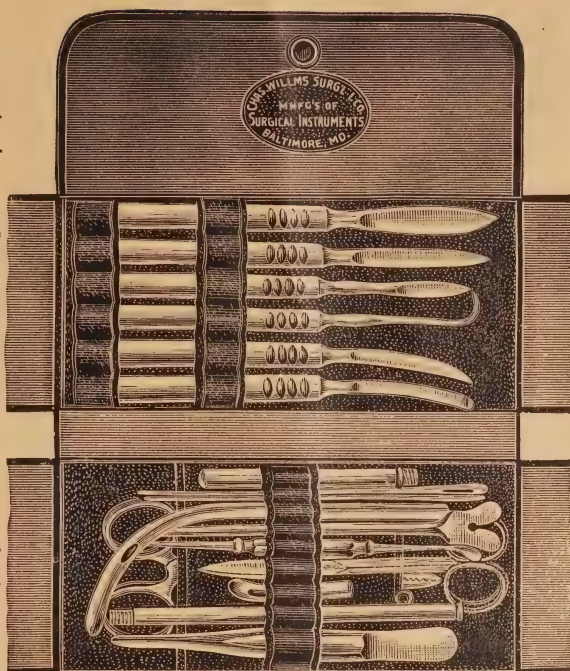
letter, accepting the position, all unworthy as I was, and asked for general instructions as to the duties of my office. The reply was, in so many words, that I was to keep headquarters informed of changes in the different Alumni's addresses, deaths and matters of interest in general. As I am a fixture and not gifted with second sight, I am at the mercy of rumor, newspaper paragraphs, etc., for such work. Do the alumni in Virginia know that I hold such office, and that any report made to me will be forwarded to the proper authorities, etc.? Such would facilitate matters very much. I have made no report since the starting of the JOURNAL (may its shadow increase), and now can add but little more than I then stated, the principal reason being I have been down, unable to practice, owing to illness, for many months. I can, however, I am glad to state, report the following, which shows how our boys will come to the front, and like our ancient friend Banquo's Shade, "will not down." Dr. S. J. Baker (Lynch Medal), 1890 Class, who has been practising here with success, was called about May this year to act as physician to The Longdale Iron Co., Rockbridge Co., Va., a much sought after position, paying about \$150 per month and many helps as to free house, horse-feed, etc., thrown in. It is needless to say the doctor gives general satisfaction. Then Dr. Thomas R. Marshall, Class 1893, who, you will find by my first report, was practising in Richmond, Va., being there Professor in Regional Anatomy, Dental, etc., in Virginia Medical College, was appointed Surgeon U. S. Army at outbreak of hostilities between U. S. and Spain, attached to 6th U. S. Infantry, served in Cuba, present at Santiago, San Juan, etc. Mentioned for gallant and meritorious conduct in the field. Now doing duty in New York with rank of Captain. Any help you can give me to better do my duty, let me hear from you. Excuse a sick man's letter, better next time. Truly wishing you and all our boys luck and money,

Ever yours fraternally,

R. G. O'HARA, M. D., '85.

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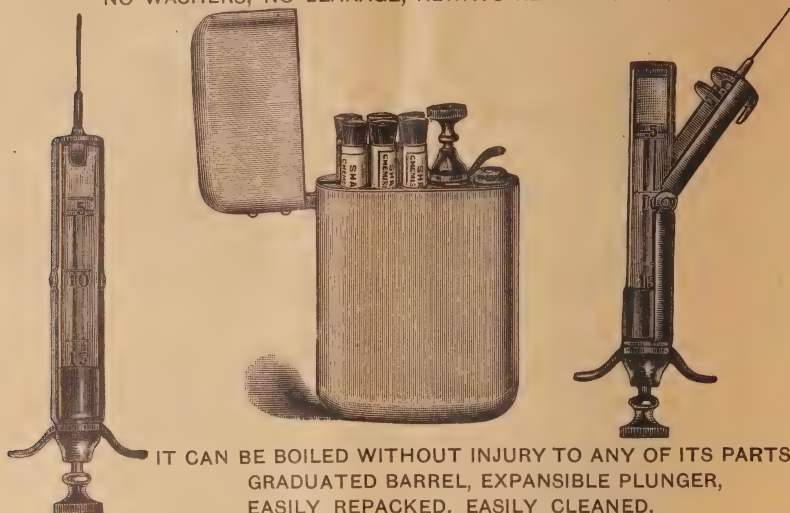
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Personal Notes.

DR. W. LEE HILL, '93, is practising at Arcadia, N. C.

DR. W. J. MOORE, '93, is succeeding well at Ashborough, N. C.

DR. W. T. HENRY, '96, has removed from Easton to Fishing Creek, Dorchester Co., Md.

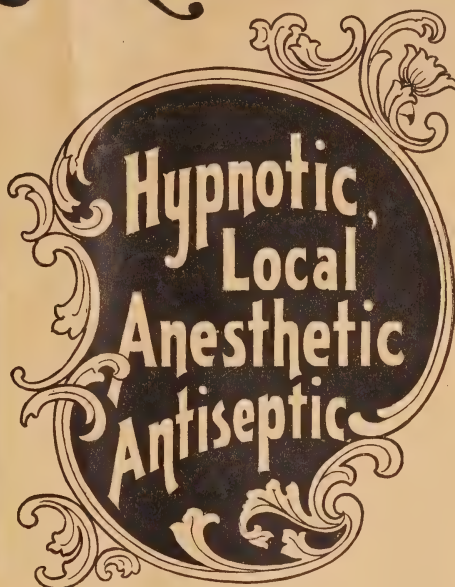
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The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

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Vol. III

No. 2

JULY, 1900

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(*Table of Contents on Page iii.*)

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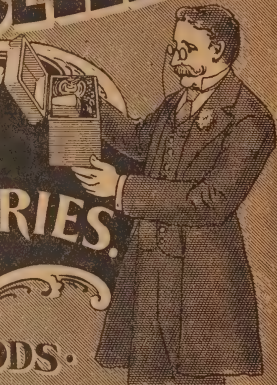
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Personal Notes.

DR. E. S. OSBORNE, '99, has located at Savannah, Ga.

DR. C. M. POOLE, '80, has a flourishing practice at Craven, N. C.

A CARD.

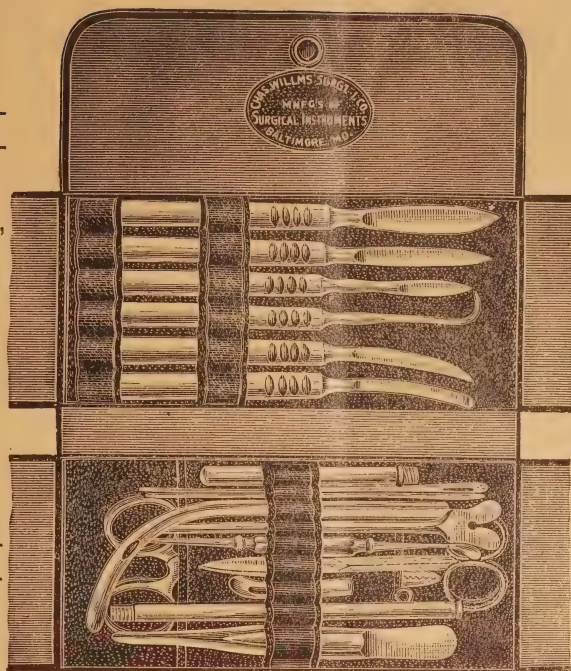
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Personal Notes.

DR. FREDERICK T. DALE, '88, has an excellent practice at Depauville, N. Y.

DR. A. A. SHAWKEY, 1900, is making a good start in practice at Charleston, W. Va.

DR. HARRY HUBBARD, '99, after leaving the City Hospital, located in Wheeling, W. Va.

DR. J. C. MEREDITH, '85, who is practicing at Manassas, paid a flying visit to the College in June.

DR. CHAS. A. RAY, '87, who is practicing at Winifred, W. Va., made a flying visit to Baltimore recently.

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Personal Notes.

DR. H. M. ROGERS, '84, of Waynesville, N. C., visited the College in May.

DR. A. N. FALKENSTEIN, '87, spent the past winter in Florida. The Doctor has recovered his health and resumed practice at Glen Rock, York County, Pa.

THE JOURNAL
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BALTIMORE.

EXTRACT FROM ADDRESS

BY DR. WILLIAM F. SMITH, '89.

(DELIVERED AT THE MEETING OF THE ALUMNI ASSOCIATION, APRIL 23, 1900.)

We have to-day all grades of physicians, from the most restricted specialist to the hard-riding country practitioner like Dr. MacLure. What place does the average physician to-day occupy in the community? There is no question but that the physician is honored by the community, respected by all, loved by many, feared by some. But what is the exact place he occupies in his own and in others' estimation? I don't want to enquire how much medicine he knows, for in these days of progress I don't think it is any longer necessary to deliver a lecture on the necessity of keeping abreast of the times in medicine. Competition will force this.

What I am interested in is, where does he stand among literary men, merchants, lawyers, clergymen? Is he regarded as a man of culture? Of course he is regarded as a learned man. He is trusted to have knowledge and skill in his line, and most people, like Silas Wegg, have respect for the doctor because he knows all about their insides. But is it akin to their respect for the plumber? To the popular mind both are wrapped in mystery. How does he stand on the broad platform where all men meet with equal footing? Is he a man of culture?

He is or must become so to follow the natural progress of the evolution of the species. The physician of the future must become not simply a man well-read in his profession, but must symmetrically round out the fullness of his life by becoming a man of culture. If he neglects this, the community is justified in placing him among mechanical experts, and to render him only just such respect as is due to his special knowledge. Besides, he is liable to become a steady-going old plough horse, shut off from many of the enjoyments of life. Too many men of science, and especially medical men, become this.

Darwin said that in the first thirty years of his life he derived great pleasure from music and poetry, but later could not endure to read a line of poetry, lost his taste for music and pictures. "My mind seems to have become a kind of machine for grinding general laws out of a large collection of facts. If I had my life to live over again, I would have made it a rule to read some poetry and listen to some music at least once every week."

Relaxation and recreation are as much a need as work. Our new brothers have spent four years in learning how to work. If these few minutes will start you in the right path and induce you to learn the proper way to rest and play, I shall consider that I have done as much, if not more for you, than all the teachers of this institution of learning.

To be always doing something is as useless for the higher purposes of growth and influence as to be always idle. One sees and feels a hundred things in the woods as he saunters through their depths which are invisible as he rushes through on a flying train. In order to give work its individuality and freshness, we must at certain times be open to such influences. Recreation is a necessity, not a luxury, which restores a man his pristine power, freshness and originality.

Anything which takes a man out of the atmosphere of work, gives him different interests, calls into activity different faculties, brings back the spirit of play. Literature offers a field for recreation seldom given sufficient thought by the medical man. What! you say, "Don't we have enough to read among the multiplicity of medical journals and books, without reading other things? And, besides,

people would look on a man who does much other reading with suspicion. His special line is medicine and what business has he outside of it."

But some people look upon wit and wisdom as a bar to the practice of medicine. When Dr. Wendell Holmes sat down behind his newly-made sign and said, "Small fevers thankfully received," those who had no fevers laughed, but those who had went elsewhere. But everyone cannot become a Wendell Holmes, and this need not prevent our taking an interest in literature; not necessarily to the extent of becoming an author. I hope that when any one of you feels that there is something he knows better than any one else, that no one else can tell it as well as he, and that he must give this part of himself to the world, I hope the inspiration will be on a medical line. But he may all the same be a lover of literature. Mabie says: "It is written apparently in American consciousness that a man can do but one thing well. If this view is sound, man is born to imperfect development and must not struggle with fate." If man has a natural aptitude for several things, I am sure his interest in those things need not detract from his exertions in the field of medicine.

I grant you that earnestness is necessary first. No triflers will ever succeed in this profession. A physician may not be an amateur in medicine—here he must be in the truest sense a professional. I have often thought that a man in a specialty becomes mechanically, therapeutically and diagnostically more expert, but the more he shuts himself up within it, the sooner he reaches his limit so far as force and originality are concerned. This is true of specialties in medicine; it is true of medicine when we consider it as a specialty and shut up all our best thoughts within its limits. We should give it the best of all our thought and work, but not all of our best thoughts. I should compare the result with the degeneration of a species by continual inbreeding. In order to get genius, talent and the best, we must harmonize with the great thoughts of the world in and outside of medicine. Inspiration comes often from the greatest minds, whether they be in our lives or not. The world is out of joint when each set of professions burrows blindly like the mole and indepen-

dently. Rather let there be proper and complete harmony among all the fraternities. We recognize that the specialist in a department of medicine must have a general knowledge of medicine. We do not admit that he can afford to neglect his general medical education, no matter how long he has practiced his specialty. Why should we not take a broader view and realize that the general principles of culture underlie and govern our best work and thought in any and all departments of medicine?

The medical student has undergone a great evolution in the last few years. The man who enters on the study of medicine is fully equipped to comprehend the beauties of literature. Why should he drop it all during his four years of medicine, or after he graduates in medicine? It is not a matter of time so much as a matter of inclination, and the only way we will get the inclination is by reading. Don't imagine that the best things to be gotten out of books are reserved for people of leisure; on the contrary they are oftenest possessed by those whose labors are many and whose leisure is limited. It is not wealth of time but thrift of time, as Gladstone said, that brings ripeness of mind within reach of the great mass of men and women. Most men give to unplanned and desultory reading of books and newspapers an amount of time, which, if intelligently and thoughtfully given to the best books, would secure in the long run the best fruits. It is a curious fact that the medical profession in most respects the most thrifty with time, should be such great spend-thrifts in this respect. This fault I think largely due to a neglect to decide in advance what direction one's reading should take, the neglect to keep the book of the hour close at hand.

There is no particular time to undertake this method; it should have begun before your student days; it should have followed through this and it should continue to follow after. Do not imagine that your literary education is complete because you graduated from a so-called literary college before starting the study of medicine. Do not imagine it is hopeless because you had not that advantage. In the true sense of the word some of the men of the greatest culture were never graduates of literary colleges. No man can seize the fruits of cul-

ture prematurely. How much do we get out of Shakespeare in our school days? We cannot enter into and appreciate the world of feeling, the wealth of beauty. We see him from an entirely different standpoint at different ages in our lives. This same Shakespeare knew how to read. He came to possess what he read. He not only remembered it, but he incorporated it into himself. No other kind of reading could have brought the East out of its grave with its rich, langourous atmosphere, steeping the senses in the charm of Cleopatra or recalled the massive and powerfully organized life of Rome about the person of the great Cæsar.

The majority of people have not learned the secret; they read for information and refreshment; they do not read for enrichment. There is such a thing as a man's intellectual character; it is formed by what he habitually thinks about. The mind cannot always be consciously directed to definite ends. The bow cannot always remain bent. In hours of relaxation, the mind wandering at will, we often find the most beautiful periods of life. If, then, we can command our meditations in the right direction and think about the great books we read, we can enrich ourselves without effort or fatigue.

Who, so much as the practicing physician, has so many moments to himself, where proper meditation brings forth a world of enjoyment? Don't imagine your study, or rather play, of literature, is to be a study of philology, grammar, construction, literary history. Although you will naturally find your literary taste better, your literary style improved, your solecisms fewer from a proper reading of the masters. What we wish to get out of literature is the enjoyment of the beauty and power. If we abandon ourselves to this we often get the same impression as from the first sight of a work of art, so fresh and instantaneous that it absorbs our whole nature. And this we will feel, and more, after we get acquainted with and cultivate a taste for the masters. This we can only get by habitually reading the best books. We get it in the same way that we get a love for nature. By daily familiarizing ourselves with Nature herself, daily fellowship with landscape, trees, skies, birds. Not by looking down a microscope. Nor will we ever acquire a taste for literature from Gray's

Anatomy. All are essential, but not one more than another. After awhile we acquire unconsciously to ourselves a power of discerning good from bad; of recognizing on the instant the sound of true method and style, and of feeling a fresh, constant delight in such works.

What, then are the books we should read in order to acquire this power? Mabie says we should of course read many others, but then we must read Homer, Dante, Shakespeare and Goethe. They hold their places because they combine in the highest degree, vitality, truth, power and beauty. They are the central reservoirs into which the rivulets of individual experience over a vast surface have been gathered; they are the most complete revelations of what life has brought and has been to the leading races; they bring us into contact with the heart and soul of humanity. Of course we do not mean that it is necessary to read these in the original; good translations are always to be had. "One evidence of their power is afforded by the fact that every new age of literary development feels compelled to translate them and interpret them afresh." They represent not only the individual experience of the author, but of the human experiences of the time and for all time. And upon this imperishable food stored up in their books by the artists of all time successive generations have fed. In some mysterious way there is a transmission of power to the reader; how we do not know. The most careless and superficial readers cannot escape their influence. The spell is cast upon them; then attention is forced and their hearts are stirred.

Do not imagine that these great works are only works for former generations and are out of date; for while it is true that these great books portray a most intimate knowledge of the times in which they were written, and bear the impress of those times in style, thought and structure, they are yet independent of them.

"A great book is a possession for all time, because a writer of the first rank is the contemporary of every generation; he is never outgrown, exhausted or ever old-fashioned, although the garments he wore may have been laid aside long ago."

I trust you will excuse me for not having talked more of the glories of the medical profession. I have chosen rather to speak of one spot

on the face of the glorious sun. Pardon me for not reciting the many valiant deeds of the scions of this noble old college. I have preferred to show you how to clean off one tarnished place from their otherwise unsullied armor. I have not prophesied of the glorious future of our little band, nor miraged the temple of fame for each one of you in the distance, but I trust I have shown you one of the cool, fragrant, shady oases in the desert.

SEPTIC THROMBOSIS OF THE LATERAL SINUS. REPORT OF A CASE, WITH RECOVERY AFTER OPERATION.*

PRELIMINARY REPORT.

BY DR. HARRY FRIEDENWALD, '86, BALTIMORE, MD.

One of the most interesting advances in aural surgery in recent years has been in the treatment of the intracranial diseases depending upon purulent otitis media and caries of the temporal bone. It is not many years since these conditions were regarded as almost hopeless. Not the least dreaded was septic thrombosis of the lateral sinus and consequent pyæmia. The first operation for the relief of this condition was done by Zaufal in 1884.

In 1889 Lane and in 1890 Ballance reported the first successful operations.

Within the last decade the number of operations has increased at a rapid rate, and it is pleasant to read of the considerable number of cases that have thus been cured.

I have myself seen several cases of septic thrombosis end fatally. One I reported to this Faculty in 1890.

Two years ago I operated upon a young lady and relieved the thrombus. The patient lived for several weeks but finally succumbed to septic pleuropneumonia which was present at the time of the operation.

It therefore gives me great pleasure to present this patient to you upon whom I have recently operated for the relief of this condition

*Patient presented and paper read before the Annual Meeting of the Medical and Chirurgical Faculty of Maryland, April 26, 1900.

with successful result, it being the first in Baltimore. I shall to-day give only a brief outline of the clinical history.

Mr. H., aged 29 years, had a severe illness ten years ago, which, as far as his statements go, lead to the belief that it was osteomyelitis of the arm; this was cured after repeated operations.

On the 16th of last December he was attacked with erysipelas, for which he was treated by Dr. Chas. F. Blake and relieved in about a week. A few days later he had an attack of acute otitis media and his physician punctured the drum-head. Pain continued and increased and January 6th he entered the City Hospital.

His condition at this time was as follows: There was severe and continuous pain in the head and neck, marked sensitiveness to firm pressure over the left mastoid process and deafness. The left drum was somewhat reddened but not bulged and showed no other pathological changes. The spot where the incision had been made was visible and was closed. His temperature was 101.2° . On examination of the blood extra corpuscular hyalin bodies were found, and quinine sulph. 10 grs. three times a day were ordered. The temperature fluctuated between 99.8° and 100.8° until the evening of January 9, when it suddenly arose within a few hours to 105.2° without the slightest chill. The temperature on the following morning was 100.5° . He was operated upon on this day. As a preliminary to the mastoid operation, a free incision was made in the drum-head and a large amount of pus escaped. On opening the mastoid the bone was found to be excessively vascular and somewhat softened. The antrum was opened and thoroughly cleaned and then the apex of the mastoid was freely exposed. In the posterior portion of the tip there was much diseased bone.

Having removed every portion that was found to be diseased, the wound was packed with iodoform gauze. The patient's condition improved somewhat after the operation, and the pain which had continued without intermission up to the time of the operation was relieved.

On the afternoon of January 11, however, the temperature again arose to 104° , falling to 101° the following morning and again ris-

ing to the former point in the afternoon. None of these rises of temperature were accompanied with chills. On the 14th and 15th the temperature fluctuated between 100° and 103° . On the 16th it fell to 99.5° , then there was again a gradual rise until 1 P. M. on January 17, when it reached 105.2° . During the time that had elapsed since the operation quinine (Warburg's tincture) and arsenic had been given without effect. The blood had been frequently examined and no trace of leucocytosis found. This fact, together with the absence of chills and the great relief of pain after the first operation, made the diagnosis of thrombosis of the lateral sinus very doubtful, but when the temperature rose on the 17th of January to 105.2° we assumed that there must be disease of the lateral sinus and proceeded to operate.

The mastoid was freely opened, the antrum exposed much more widely than before, then an incision was carried from the middle of the wound backward. The periosteum was removed from the bone and we proceeded to expose the lateral sinus. The sinus was laid bare forwards and backwards in order to find, if possible, where the disease took its origin. The sinus appeared to be normal, but in one part showed slight bluish discoloration. We made a very small incision and finding that there was no hemorrhage, opened the sinus freely and removed the outer wall. At first we met a solid dark thrombus, but as we approached the anterior portion of the sinus a very large amount of pus escaped and continued to flow out. Whenever the patient coughed more pus was forced out of the lower end. We opened the sinus until we reached a point near its union with the jugular vein when bleeding occurred, and then we proceeded backward and upwards until we got free hemorrhage. The entire extent of the sinus opened measured about $2\frac{1}{2}$ inches. The jugular vein was not ligated. Cultures were made of the pus from the sinus and streptococci developed. After the operation the patient's temperature fell and for a number of days remained between 101° and 102° with good pulse. At the end of a week or ten days we found that whenever dressings were allowed to remain over a day or two there was rise in temperature.

On January 27, ten days after the second operation, the temperature again rose to 105° , due to slight retention of pus in the wound.

On February 1 the patient, after having been several days with normal temperature, got a rise of temperature to 105° , accompanied by chill, the first he had had. This was due to the retention of a large amount of pus in the posterior portion of the sinus which had closed more rapidly than was desired. Since its evacuation the temperature has remained normal. The patient rapidly improved, regained his great loss of weight and is now (almost three months after last operation) in good health. There is still a small fistulous canal leading toward the antrum, which we hope will soon close.*

In conclusion I wish to direct your special attention to the absence of leucocytosis and still more to the absence of chills in this case.

A CASE OF PUERPERAL CONVULSIONS.

BY DR. M. SAVAGE, '95.

Mrs. F. M., aged twenty-four years, well developed, about 5 feet 6 inches high with a negative family, and a good personal, history. Primipara, six months pregnant. During her second month of pregnancy she had some morning sickness; at the beginning of her pregnancy her feet and ankles became swollen and she suffered from headaches and disturbance of vision. Soon after she had some swelling of the face and about the wrists, and often had persistent vomiting. When first seen, on February 6th, she complained of headache, some cough and dyspnea. She had edema of lower extremities with marked pitting on pressure; there was no swelling of the face, but puffiness about the wrists. Her pulse was 70, and of high tension; urine pale, specific gravity 1014, and contained a large quantity of albumin. At 1 A. M. the patient was seized with constant vomiting and pain at the epigastrium. Three hours later she had a convulsion which lasted about a minute, chiefly involving the muscles of the face and upper

*The wound healed completely in a few weeks, and the patient is now enjoying the best of health. (July 1, 1900.)

extremities. The convulsive paroxysm was preceded by a condition simulating fainting and lasting about half a minute. Sopor followed the convulsion, and fifteen minutes later she had another convulsive seizure with considerable cyanosis, likewise followed by a comatose condition, which continued nearly an hour, when she had a third convulsion of about one minute's duration; this time some opisthotonos was noticed. After she had been unconscious for about two hours she vomited persistently and complained of headache. Examination of the uterus showed that the cervix was not enough dilated to admit a finger.

Upon the advice of Dr. Wm. S. Gardner she was given ten minims of Norwood's tincture of veratrum viride hypodermically and repeated five minims every half an hour until three doses were given, when the pulse went down from 108 to 60. The bowels were opened by a few drops of croton oil placed on her tongue, and kept loose by doses of pulv. jalap comp. 3ss.; profuse perspiration was produced by wrapping her up in blankets and exposing her to hot air derived from a lamp by means of a bent stove-pipe.

February 8th. Patient slept several hours during the night, vomited five or six times, bowels and skin acted freely, and voided about two pints of urine during the 24 hours. The pulse was kept down below 60 by veratrum viride given by mouth.

February 9th. Had cough and dyspnea, otherwise condition the same.

On the following day the edema of the legs was almost completely gone, but there was some swelling about the wrists and hands.

February 11th. Patient was again taken with vomiting, and towards evening she had convulsions followed by some drowsiness but not coma. Her urine still contained a large quantity of albumin. By this time her cervix was dilated to admit a finger, and termination of pregnancy was decided on. Two soft rubber bougies were inserted into the uterus alongside the membranes and left there. They fell out on the following day, and as the patient felt quite comfortable no attempt was made to replace them. She had no labor pains until three

days afterwards, when with a few pains she gave birth to a dead decomposed six months old fetus. A few days later she left the bed. Examination of urine still showed the presence of albumin.

REPORT OF A RARE CASE OF MONSTROSITY.*

BY DR. H. G. BECK, '96.

The subject of Animal Teratology—the morphological science treating of malformations and monstrosities—has within recent years received much attention by careful and scrupulous observers, who succeeded, according to their views, in establishing the principles governing these abnormalities upon a strictly scientific basis. With regard to the ætiology it may be said, without reserve, that there has been a longer record of superstition identified with it than with any other condition or disease.

Of the three most commonly alleged causes, viz., maternal impression, mechanical impression and injury to ovum, the former was practically the only one receiving recognition prior to the present century. Indeed, it is remarkable that such an inexplicable and illogical theory should almost unanimously be accepted by all races and peoples for nearly four thousand years. The earliest record illustrating the antiquity of this belief is made in the Bible (Gen. xxx). The older writers frequently referred to it. The subject has gained entrance into fiction through the minds of such men as Goethe, Scott, Dr. Holmes, Dickens, Read and Hawthorne.

Herbert Spencer was firmly convinced that there was some truth in it. With such strong expressions of opinion in favor of maternal impression, it is but natural to suppose that investigators felt loath to take up the scientific side of the question. This, however, has been done, and we now have a clearer conception of how and why these changes take place, and are prepared to offer a more rational explanation for their cause and for the relation existing between the cause and the effect.

*Exhibited before the Medical Society of the College of Physicians and Surgeons, and donated to the College Museum.

It is mostly in the embryonic period, *i. e.* in the first three months of intrauterine life, that the deviations from the natural course of development occur, which, ultimately, at the time of birth, result in monstrosities. However slight these early traces of deviations may be, at the end of the period of foetal life they may have attained proportions of a sufficient degree to be markedly deformed.

For purpose of description, monstrosities may conveniently be divided into two distinct and separate groups:

I. Monstrosities from defect of single parts.

II. Monstrosities from failure of union of contiguous lamina.

Redundancies are quite common in the first group, the simplest form being that of the sixth digit. Other forms are an extra rib or an extra vertebra; if the coccygeal, it may present the appearance of a rudimentary tail. Of the soft structures the supernumerary nipples are by far the most common.

It is the second group that especially interests us in this report.

In this group may be classified many of the commonest varieties, as well as practically all the varieties of the rarer and more serious forms of congenital malformations. To get a more definite appreciation of this group of monstrosities it is necessary to acquaint ourselves with a certain transition in the course of the development of the embryo. Originally the embryo is a circular, flattened disc spread out on one pole of the yolk. This is formed into a cylindrical body with four appendages. The free margins of the disc (ventral laminæ) fold inwards to meet in the middle line forming the ventral canal and so close in the pelvic, abdominal, thoracic, pharyngeal and oral cavities. In the meanwhile, two parallel longitudinal ridges have grown up on the back and united in the middle line, in a similar way, to form a second canal—the neural canal. The lower three-fourths is of uniform size; the upper fourth expands out into a wide chamber for the reception of the brain. All vertebrates develop in this manner. In the event of any portion of these two embryonic lines of junction failing to unite, monstrosities of various degrees may result.

The most familiar form, harelip, with or without cleft palate, is the

result of a defective closure of the extreme upper end of the ventral laminae. A gap in the lower end of the neural canal leaves a deficiency in the lumbar vertebral arches, through which the membranes of the cord protrude containing spinal fluid, causing the condition known as hydrorrhachis which is dependent upon the osseous defect—spina bifida. When this occurs in the upper vertebræ the skull, too, may be involved; indeed, the entire calvaria may be absent (acrania), as also the brain and its membranes—anencephalous.

An extremely rare condition is the association of acrania or a partially developed vertex with encephalon—encephalocele.

Even a rarer phenomenon is the association of a brain containing large fluid spaces—distended ventricles—with acrania—hydrancephalocele.

It cannot always be attributed to want of formative power to close the neural canal. The spaces in the cord and brain containing fluid may become overdistended and thereby prevent the closing of the skull; congenital hydrocephalous is brought about in this manner, only here the neural laminae unite properly in the median line and the ventricles of the brain are enormously distended with fluid.

Innumerable experiments on eggs of fishes, birds and insects furnish abundant corroborative evidence in support of this view. Ova of certain fish have been proved to be especially apt to produce malformed young. If an egg be inverted so as to place its germinal portion in an unnatural position the chick will be deformed, and if similarly treated during the period of incubation, distinct evidence of the abnormal position of the egg will be shown in the chick. Other agencies that will tend to produce malformations are: (a) violence, such as in transit or when purposely disturbed during the process of incubation; (b) direct mutilation of the ovum; (c) injuries to amnion and sac; (d) temperature above 42° or below 41° Centigrade; (e) improper supply of oxygen, etc.

These and many other experiments, together with our present knowledge of embryology, will lead one to conclude with Lewis (American Journal of Obstetrics, July, 1899), viz., "All malformations and monstrosities can be explained by purely mechanical and

physical causes entirely remote from psychic influence, so that there is never any reason to invoke the mysterious or supernatural to explain natural phenomena."

The case I report is one that occurred in my own experience in private practice. It belongs to the anatomical category which characterizes the second group of cases.

The mother, æt. 25, III para, had always enjoyed good health until the summer of 1898, when she had an attack of typhoid fever. Her first labor (May 13, 1898) was strictly normal and at full term. Every feature of the child, which is now living and in good health, is perfect. The second was a miscarriage, April 20, 1899, in the fourth month of pregnancy, the fœtus showing no signs of malformation. At her last parturition, February 3, 1900, the end of the seventh month of pregnancy, she gave birth to this remarkable monster. The family history in this regard is absolutely negative on both sides. There is positively no evidence of maternal impression.* She has not been able to recall one incident which transpired during her period of gestation that could possibly have had any influence upon the child. She suffered a great deal from sympathetic disturbances, but there was nothing extraordinary in this respect. She sustained no injury nor has she had any intercurrent disease.

The child was still-born; the position and presentation were not definitely ascertained on account of hydramnios, and the sudden spontaneous delivery after a few vigorous uterine contractions. This specimen, as you see well illustrated in the figures,† presents all the combined features of harelip, cleft palate, acrania, hydrancephalocele and spina bifida, an extremely rare and curious combination. The child, female, weighs 219 grams, measures 27 cm. in length and 24 cm. in circumference of the body. In Fig. 1 the most striking condition is the absence of the cranium, or more particularly, as seen in the picture, the absence of the cranial portion of the frontal and parietal bones. The harelip and cleft palate are also very well shown.

*Dr. W. T. Watson exhibited a child with a caudal appendage at the Johns Hopkins Medical Society which was born about the same time, and in which he also fails to get a history of maternal impression.

† The figures have been reproduced from photographs taken by Dr. S. Butler Grimes.

The eyes forming the uppermost part of the head stand out prominently. The eyeballs are bulging, so that the lids do not properly close. The nose is broad and distinctly flattened. The neck is not well defined; in fact, morphologically speaking, one may say it is entirely absent, the head being an integral part of the body. In place of the restricted portion there is a very decided elevation due to a large crescentic fold under the chin extending back over each shoulder. The right ear, relatively large, is fairly well formed and rests upon the shoulder.

Fig. 2 shows the hydrocephalic brain and the cord and their membranes exposed and unprotected by osseous structure. The general contour and atomical outlines approach very nearly those of a normal brain having two distinct hemispheres separated by the longitudinal fissure. Each hemisphere is again subdivided by fissures into lobes. The left is somewhat smaller and less characteristically developed.

The longest transverse diameter of the brain is 7.5 cm.; the antero-posterior is 5 cm. The circumference at the base measures 20 cm. A flat circular plate of bone 2.5 cm. in diameter is imbedded under the membrane in the upper, outer and posterior quadrant of the right hemisphere. This is the only evidence of ossification in the calvarian bones.

The cerebral meninges almost unite at the base, forming a pedicle by which it is attached to the base of the skull and is continuous with the spinal meninges.

In both hemispheres the ventricles are distended with fluid which may be expressed through a common duct the size of a small goose quill, opening externally at the base in the median line.

The foramen magnum is entirely absent. The vertebral arches are deficient from above down to the lower dorsal region. The interspace, 2.5 cm. wide, forms a broad, flattened surface which supports the cord and its membranes. The rest of the body and the extremities are apparently normally developed.



FIG. 1.—SHOWING HARELIP, CLEFT PALATE AND ACRANIA.



FIG. 2.—SHOWING ACRANIA, HYDRENCEPHALOCELE AND SPINA BIFIDA.

Mrs. G., aged 27, nullipara, had her regular menstrual period December 31, 1899. She missed it in January and on February 8 she had some discharge of blood, accompanied by considerable pain. She thought the delayed menses and pain were due to a cold. A slight bloody discharge continued, but she did not call in her family physician until February 21.

About March 10 she passed a clot of considerable size and it was thought that she had a miscarriage. The discharge of blood continuing, the attending physician curetted her. The patient seemed to be relieved for three or four days, when all the symptoms of pain and hemorrhage returned with increased severity.

I saw the patient first in the evening of March 23. The history given me was that two weeks previously she had had a miscarriage, had been curetted, and since then had had severe pelvic pain and fever.

At the time her pulse was rapid, temperature 102° . The pelvis was filled with a mass within which the uterus could not be outlined. The vault of the vagina was so sensitive that it was impossible to make a satisfactory examination. But from the history given and present condition, I considered it a case of pelvic infection, such as are so common after miscarriages. At the time I expressed the opinion that it was hardly probable that she could escape without operation, but advised that she be given a saline and her symptoms noted. The 24th and 25th she was quite comfortable, but during the night of the 25th the pain returned and her physician reported to me the 26th that she was again worse with a temperature of 103° , and arrangements were made to operate the next morning.

When I saw her the second time, on March 27, her pulse was very rapid and temperature 104° . Under anæsthesia the uterus was found pushed up against the symphysis and Douglas' cul de sac distended with a fluctuating mass.

A long incision was made in the posterior wall of the vagina, which was afterward stretched until it would easily admit three fingers. The peritoneum was not opened. A large quantity of black, foul-smelling fluid and clotted blood was evacuated. When the pelvis was

finally free from this a considerable stream of blood of lighter color began to flow, indicating fresh hemorrhage. Three yards of sterile gauze was packed into the cavity and the vagina tamponed with wet absorbent cotton. This completely controlled the hemorrhage.

March 28. Temperature 99°; patient has been entirely free from pain, slept well, voided urine normally, and said she felt better than she had for weeks. A part of the vaginal tampon was removed.

March 29. The remainder of tampon removed.

March 30. About one yard of the gauze pack was removed.

March 31. Temperature 100°, the highest since operation. The remainder of the gauze removed.

April 1. Temperature normal. Since the 1st she has improved rapidly and was out of bed on the 5th.

Before attempting a posterior vaginal section for ruptured extra-uterine pregnancy preparation should be made to make the occasionally necessary abdominal section to control hemorrhage. It is certainly unnecessary to do the precautionary abdominal section first.

Many of these patients, thinking at the beginning of their illness that they have nothing serious, neglect sending for a physician and then drift along until they are in such a condition that it is impossible or inadvisable to remove them to a hospital. As a result many of these operations must be done in private houses, where the possibilities of asepsis are not the best; where an abdominal section is an extremely grave affair; but where the vaginal operation can be done with safety. The rare cases, in which the hemorrhages give trouble and which cannot be controlled by the gauze pack, can be opened through the abdomen and the vessels tied. Even then the patient is in a better condition than if the vaginal section had not been made.

The points in favor of the vaginal method of operation are:

1. In the infected cases the danger of infecting the general peritoneum is avoided.
2. No organs are removed.
3. The shock of operation is less.
4. The convalescence is much shorter.
5. All immediate and remote possibilities of trouble with the abdominal wound are avoided.

STUMP PREGNANCY.*

BY DR. JOHN C. MORFIT, '96, ST. LOUIS, MO.

In August, 1897, M. A., aged twenty-three years, produced on herself an instrumental abortion. She was a working-girl in a department store, and to cover up suspicion, had not remained away from her duties, but endured the pain while on her feet for a large portion of many days. This was the second experience of the kind she had had. She was referred to me the latter half of August, 1897. There were all the symptoms of pelvic inflammation; fever of a remittent type, pain and tenderness, especially in the lower abdomen, exaggerated on exertion or palpation. There was constipation and distention. There was, also, a muco-purulent vaginal discharge, very abundant, but not showing any gonococci—only the ordinary pus-producing organisms. The womb was soft, somewhat enlarged, very tender and red. In the cul-de-sac to the right a mass about as big as a hen's-egg could be detected, this was elastic, but did not fluctuate. The left ovary and tube could be felt, but were not pathologic. The mass on the right, I took to be a pyosalpinx, resulting from an infection incident to the criminal abortion.

Operation was decided on. The tube and ovary were removed, and about an ounce of pus escaped from the distorted and distended tube. At the time, I did not notice how far from the uterus I applied my ligature. Recovery was uneventful and rapid. The woman gained her accustomed robust health, except for the necessity of removing, six months after, one of the interrupted buried silkworm-gut sutures which was used in the fascia. This is a practice I have discarded, having substituted cumol catgut as a suture, and from which I have never experienced bad results in a considerable number of cases.

December 17, 1899, two years and four months later, I was called in the evening to see this same patient. She had a weak, thready pulse that I could not count; seemed worried; the lips were pale, the hands and feet cold, respiration quick and shallow, with nostrils dilating at each respiratory excursion; she told me in slowly spoken

words, that she had been two weeks overdue in her period and believed she was pregnant. She complained of the most intense pain in the right side from the shoulder to the hip, with especial reference to the right iliac region. She was so weak, nervous and excited that I did not attempt to make a thorough examination. There was no mistaking hemorrhage, however, with such symptoms. I gave three-eighths of a grain of morphine and one-thirtieth of a grain of strychnine hypodermically, and in half an hour injected a quart of salt solution into the rectum. This was retained and the pulse soon became steady and was 120; the temperature was below normal. As she was quiet and calm I left her and returned early in the morning. At this time I was able with less difficulty, but not without causing the patient considerable pain, to examine the abdomen, which was much distended and tympanitic except low down posteriorly at the sides, where there was bulging and dullness. The pulse was now 110 and much stronger than on the previous evening, but the patient was too weak to stand anything and was kept at absolute rest. I repeated the salt solution per rectum and encouraged the patient to drink all the liquid possible. Her great thirst made her comply frequently. I then left her to prepare for operation and arrange for her to be carried on a stretcher to a near-by hospital. Before I could barely inaugurate my plans, I was recalled and found the sufferer in a state of profound collapse. There was absolutely no radial pulse and that of the carotids was only perceptible. Listening over the heart, I could hear only a continuous whirl, no well-defined beat interval could be detected. The patient was stupid and responded to questions in an indifferent manner. I had concluded from the first that this was a case of ectopic pregnancy and this second collapse was no doubt due to a recurring hemorrhage. At both times the woman's condition was such as to preclude the thought of an immediate operation. I could only hope to get her in condition where she could be taken to more favorable surroundings and anæsthetized. Much to my gratification, I was able to get a favorable response to another quart of salt solution per rectum, and brandy, strychnine, nitroglycerine and morphine hypodermically.

By the next day at noon, or thirty-six hours after my first visit, I had her in the hospital, where she arrived with a pulse of 108, weak and thready, temperature 97° F. A pint of normal salt solution was immediately injected under each breast into the loose pectoral tissue. The same fluid was administered by the rectum, but not retained. Fortunately there was no vomiting, and the patient took a considerable quantity of fluid by the mouth. Pain was complained of and morphine and the heart stimulants were administered freely by the hypodermic method. At 8 A. M. of the second day in the hospital the pulse was 150, weak and compressible, and the temperature at the same time was 101°. Both remained at this point, but the pulse became stronger and the pain greater in the afternoon. The pain and tenderness were now confined to the right iliac region and were most acute. The other abdominal symptoms were somewhat intensified.

At 5 P. M. I decided to risk an operation, although I had little hope of bringing the patient off the table alive. I made the incision in approximately the same line of the first operation of two years previously, and encountered several embedded silkwormgut sutures. There was a band of adhesion running backward to the fundus of the cecum, just to where the vermiform appendix is given off. This two-inch adhesion resembled a thread of catgut.

I only noticed this incidentally, my first object, of course, being to find the bleeding point and stop the hemorrhage. Hindsight being sometimes better than foresight, I recall that I endeavored to stop the hemorrhage and then found the bleeding point. The belly was full of black, but sweet-smelling clots, and there was quite a quantity of fluid red blood. Knowing that I had one time removed the right appendages, I sought the left adnexa, and felt my way through the clots and applied a forceps to the proximate portion of the left broad ligament. With this pressure I felt at ease to proceed to the toilet of the belly, and must have removed more than a gallon of clots and fluid blood. What was my surprise on getting a clear field to see that the oozing was from the stump of my old operation. There it was, about three-fourths of an inch long, and ruptured, presenting a fuzzy placenta to my view. Another forceps was applied to the right

side, both tubes ligated close to the womb, and the distal portions removed. The abdomen was then filled with normal saline solution and sewed up with several layers of buried catgut sutures. The patient was returned to bed, and everything done to sustain strength and lessen the shock. Artificial respiration was kept up for over two hours, salt solution was injected per rectum, under the breasts, and into the cellular tissue of the thighs. Twenty hypodermic syringe-loads of brandy, besides strychnine and nitroglycerine were administered. For many hours the patient seemed to be only artificially alive, but our persistent efforts were finally rewarded by a gradual return of consciousness, and more emphatic evidences of real life. In four weeks the patient walked to her carriage and was driven home. Her recovery would have been perfect, except for the annoyance caused by her burning her legs with hot-water bottles. To-day she is a picture of perfect health and suffers none. In the ovary removed there was a large ruptured Graafian follicle.

This, I believe, is a variety of extrauterine pregnancy which has never before been met with, and for that reason, I have named it *stump pregnancy*, it having occurred in the remains of a tube, the proximal end of which I had not entirely removed. The absence of the ovary and most of the tube on the right side, the occlusion by ligature of the stump, the presence of a normal ovary and tube on the left side, and a large corpus luteum being present in the only ovary, lead to but one possible conclusion. The fertilized ovum came from the left side, passed through the left tube and the uterine cavity up into the remains of the tube on the right side, where it began to develop and finally ruptured the tube into the abdomen.

This upsets the theory, and heretofore generally accepted view, that ectopic pregnancy is due to some mechanical or inflammatory hindrance to the normal downward passage of the fertilized ovum. I believe this case proves quite clearly that the ovum may travel either up or down, and wherever an ovum may be fertilized in the ovary tube or uterus, it seems certain that it can come from either side and go everywhere and anywhere before anchoring itself preparatory to development.

3535 Olive Street, St. Louis, Mo.

ANEURISM OF THE ABDOMINAL AORTA.

(FROM CLINIC OF DR. W. F. LOCKWOOD.)

REPORTED BY DR. R. C. FLEMMING, '00.

Thomas G., colored, age 25, single, stevedore by occupation, admitted to City Hospital on afternoon of June 4, 1900. The family history is not important. Account of previous sickness included one attack of rheumatism and one of malarial fever. There was a history of venereal disease, contracted four years before his admission to hospital, which was described as "four or five sores," for which treatment was neglected, and which got well in six months. For several years he has been a hard gin-drinker, averaging as high as 10 or 15 drinks daily. He has not been able to work for a month, but was able to walk to hospital at time of admittance. This latest illness, for which he sought treatment, began four weeks prior to his admission. Pain in his back was one of its earliest symptoms, and that had become steadily worse, and was relieved by no position of body that he could assume. Pain in the abdomen shortly followed, and sleep, for three weeks, had been rarely had. He also suffered much from hiccoughing, anorexia, nausea and occasional vomiting.

On examination, rigidity of the abdominal muscles was noticed, and was most marked in the upper zone, and to the right of the median line. The epigastric region was especially sensitive to pressure. There was noted, also, an apparently pulsating, slightly expansile mass in the epigastric region, dull on percussion. No thrill or bruit was noted. Pulsation in the femorals was weak. Hence, from these symptoms and physical signs, a diagnosis of abdominal aneurism was made.

At 8 A. M., June 5, patient complained of agonizing pain in the back; the skin was cold and clammy, and his general condition indicated shock.

By the application of heat and the administration of morphine and strychnine, his surface warmed, his pulse became strong, and he shortly fell into an apparently normal sleep.

At 1 P. M. of the same day he awakened suddenly, crying out with pain, and almost immediately became comatose, and died in 15 minutes.

An autopsy revealed a ruptured aneurism of the abdominal aorta, at a point just below the diaphragm, at which there were two tears, one of them partially limited by adhesions.

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THE JOURNAL
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OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

ALUMNI ASSOCIATION.

The annual meeting of the Alumni Association was held at the College building Tuesday evening April 24, 1900, the President, D. J. Gorse Simmons, '91, in the chair.

Dr. Todd, the manager of the JOURNAL, presented to the College a bound volume containing all the numbers of the JOURNAL published.

A vote of thanks was extended to Drs. Todd and Gardner for their work in publishing the JOURNAL.

The following officers were elected: President, Dr. William F. Smith, '91; First Vice-President, Dr. Meigs J. Bartlett, '95; Second Vice-President, Dr. Louis H. Stick, 1900; Secretary, Dr. Alexis McGlannan, '95; Treasurer, Dr. Charles Emil Brack, '95; Executive Committee, Dr. H. Friedenwald, '86, chairman, Dr. H. S. Jarrett, '84, and Dr. Harvey G. Beck, '96.

Dr. William F. Smith delivered the annual oration, an extract from which is published in this number. The oration was followed by a smoker and musical program, which was arranged by Dr. Brack.

At a recent meeting of the Faculty, Dr. C. Hampson Jones resigned the chair of Obstetrics and was elected Professor of Hygiene.

Dr. George W. Dobbin was elected Professor of Obstetrics.

Dr. Harvey G. Beck was elected Associate Professor of Clinical Medicine.

Dr. Carey B. Gamble, Jr., was elected Associate Professor of Clinical Medicine.

Dr. H. H. Hayden was elected Associate Professor of Human and Comparative Anatomy.

Dr. J. Hall Pleasants was elected Associate Professor of Clinical Medicine.

Dr. Sylvan Rosenthal was elected Demonstrator of Bacteriology, Dr. S. Griffith Davis Demonstrator of Anatomy, and Dr. S. Butler Grimes Demonstrator of Anatomy.

Personal Notes.

DR. REID HUNT, '96, has been elected Associate Professor of Pharmacology in the Johns Hopkins University.

DR. J. T. DAVIS, '98, has been practicing at Hampton, Va. He is now in Baltimore doing post-graduate work.

DR. D. B. HARTINGER, '94, of Middleport, Ohio, has been spending some time in Baltimore doing post-graduate work.

DR. L. V. GUTHRIE, '89, Superintendent of the Second Hospital for the Insane at Spencer, West Virginia, was in Baltimore recently.

DR. J. S. JOHNSON, '76, died at Clausen, Alabama, August 4, 1899. At the time of his death he was a member of the County Board of Health and County Examiner.

DR. DANIEL ALBERT BERNDT, '96, of Portsmouth, Ohio, has an elaborate article on "Coughing" in the November number of the Columbus (Ohio) Medical Journal.

DR. S. F. HUGHES, '99, is Resident Physician at St. Agnes Hospital, Baltimore. DR. J. M. LEONARD, 1900, is Assistant Resident Physician at the same institution.

DR. H. V. CASSADAY, '93, died at Mt. Pleasant, Utah, April 10, of la grippe. He had been located at Mt. Pleasant only about one year but had built up a valuable practice and was highly esteemed by the community.

DR. HARRY FRIEDENWALD, '86, contributed an article on "Plexiform Neuroma of the Upper Eye-lid" to the Welch Festschrift. All the articles in the volume, which is a very handsome and valuable one, were contributed by the pupils of Dr. William H. Welch.

DR. EDWARD V. MURPHY, '99, was married to Miss Katherine C. Bergin, at Newport News, Va., June 25.

The Doctor has recently purchased a fine residence and office on N. Main Street, Fall River, Mass., and his prospect of success is excellent.

The members of the class of 1900 were fortunate in securing hospital positions. Drs. Rohrer, Penton, Collier, McAvoy, Stick and Flemming were appointed at the City Hospital; Drs. O'Dwyer and McCollum to the Maternité; Drs. McKnight and Jessure to Bay View; Dr. Leonard to St. Agnes Hospital; Dr. Watson to the Presbyterian Eye and Ear Hospital, and Dr. Perkins to Spring Grove. In addition to these several have secured positions out of the city.

DR. C. D. EVANS, '82, of Columbus, Neb., has sent the JOURNAL a valuable reprint upon the "Treatment in Compound, Comminuted and Non-Union or Ununited Fractures." He reports a case of operation upon an ununited fracture of the tibia. He cuts down upon the fracture; dissects off the periosteum; saws off enough of the ends of the fragments to get to healthy bone; unites the ends of the bones with No. 3 catgut; puts on a sterile dressing and then puts on a splint made of band iron bent to the shape of the sound leg; one strip is placed anteriorly and one posteriorly, and secured by plaster bandages above and below the point of fracture. Bows are made in the iron strips so that they will arch over the point of operation, and so that the dressings can be renewed if necessary without disturbing the splint. The method is undoubtedly an excellent one and alumni who are interested in this field of work would do well to write to the Doctor for an illustrated reprint describing the operation in detail.

ALBUQUERQUE, N. M.

W. S. GARDNER, M. D., Baltimore, Md.

My dear Doctor.—Enclosed please find one dollar (\$1.00) as yearly subscription to the JOURNAL. The receipt of the JOURNAL is like the visit from an old friend.

P. & S. men are very few in New Mexico; and so far as I have found there are but two of the Alumni in the territory, viz. Dr. T. P. Martin, of Taos, Secretary of the Territorial Board of Health, and myself.

I met Dr. Martin here last spring and he made special enquiry for Drs. Gardner and Smith.

This is a very nice little city and is rapidly coming to the front as a health resort, more especially for tubercular disease than any other. I came here in March of this year with my wife, who was suffering with pulmonary tuberculosis, and the effect of the change has been very satisfactory. She is so much improved that I feel safe in advising any of the P. & S. Alumni having patients suffering from tuberculosis to send them here.

Glad to hear of the success of the College, and am proud of its new building.

Wishing you and the JOURNAL the greatest success, I remain,

Yours fraternally,

J. FRANK RUTHERFORD, '92.

BROOKLYN, N. Y., January 30, 1900.

WM. J. TODD, M. D., Baltimore, Md.

Dear Doctor.—Please find enclosed check for \$2 for the ALUMNI JOURNAL. It is indeed a splendid little publication, and I rejoice to hear from my dear old comrades and teachers from month to month.

I am practicing in this City of Churches ever since my graduation in '93, and am having more than I could possibly attend to. Am a member of the Kings County Medical Society and of the Phys. Mut. Aid Association of New York, and am holding salaried position of 26th Ward Dispensary for the last four years.

1901 will very likely see me in Europe, where I intend to visit the principal hospitals and clinics of London, Paris, Vienna and Berlin during the months of September, October and November.

Kindly give my heartiest greetings to Drs. T. Opie, H. Friedenwald and Wm. S. Gardner, and oblige,

Fraternally yours,

MICHAEL A. COHN, '93.

521 Stone Ave.

LAND OF PROMISE, VA., July 25, 1900.

W. J. TODD, M. D., Baltimore, Md.

Dear Doctor.—I enclose one dollar for the ALUMNI JOURNAL. I am always anxious to see the JOURNAL come, as it brings me news of the doings and whereabouts of so many of my old friends and classmates. I am a '94 man and have been at this place ever since my graduation. I have no cause to regret the choice of the P. & S. as a college, medicine as a profession nor the Land of Promise as a location. The latter has given me all it promised—a good wife, two nice boys, plenty to do and a good living. I am glad to know that our old College allows none to excel her in any respect, and hope to be able to visit her in the near future and see the many changes and improvements. I have many warm friends in Baltimore whom it would give me great pleasure to see, and of them none do I love and respect more than Prof. Wm. F. Smith. With best wishes for the success and prosperity of the College of Physicians and Surgeons and every one connected with her, I am,

Very truly yours,

JULIAN C. BAUM, '94.

NORFOLK, VA., April 6, 1900.

W. J. TODD, M. D., Postal Station No. 202, Baltimore, Md.

Dear Doctor.—It is with inexpressible grief I assure you that I have to announce to the Alumni, and especially to the members of his class, the death of Leroy T. Nash.

He died November 18, 1899, after a short illness, which was due to typhoid fever.

At the time of his death he was enjoying a large and lucrative practice; was also examiner for several life insurance companies. He was kind and gentle as a lamb, ever ready at all times to alleviate the pain of his fellowman and a monument to his Alma Mater.

Before closing this letter I should, in passing, state that P. & S. men in this city are to the front. Among them are C. F. Newbit,

who is Health Commissioner of our city; Jas. G. Riddick, who is a candidate for Mayor, and C. D. J. Macdonald ('97), for Physician to Almshouse. In closing I may say I shall be present at the banquet of 1900, and hope to see many men of '98 and especially Geo. M. Baily.

Yours very truly,

L. J. GALLUP, '98.

PERU, N. Y., April 26, 1900.

DR. WM. S. GARDNER.

Dear Doctor.—Enclosed please find one dollar for THE JOURNAL OF THE ALUMNI ASSOCIATION. I have been in practice here eighteen years. Have now sold out real estate and personal property, intending to remove to Denver, Colo. Expect to spend the summer in the mountains of Northern New York and the winter in the College of P. & S., Baltimore, and to Denver in the early spring of 1901. My P. O. address for the present will be Peru.

Faternally yours,

FRANK D. KINSLEY, Class 1882.

HARTFORD, CONN., March 19, 1900.

Dear Doctor Gardner.—Your letter of February 23 relative to location of Dr. T. E. Morrison received. I beg to be pardoned for not answering before, but I mislaid same. The Doctor has not been here for about four years and his whereabouts are unknown, even his own family have not heard from him in years and can't locate him.

I hope to be in Baltimore before long and will try and see you. My success has been unlimited since I located here. I took a post-graduate course in Berlin and Vienna last year; am doing some good surgery, and have all the general work I can swing. Hope you are well and prosperous. Wish you would add my name as a subscriber to your JOURNAL and send me bill.

With best wishes, I am,

Sincerely yours,

J. B. BOUCHER, M. D., '94.

McSHERRYSTOWN, PA., January 16, 1900.

Dear Doctor.—Enclosed find check for the renewal of my subscription for the JOURNAL for 1900. I am enjoying the best of health,

weigh 212½ pounds, and have plenty of work. I was recently elected first vice-president of the York County Medical Society. Wishing the JOURNAL all the success in the world, I am,

Yours fraternally,

A. C. RICE, '97.

COLOSI, ISLAND OF PANAY, P. I., 23rd of May, 1900.

DR. HARRY FRIEDENWALD, Baltimore, Md.

My dear Doctor.—We sailed from Frisco on March 17th aboard the U. S. Army Transport "Meade" and arrived at Honolulu on March 25th. We were all very anxious to go ashore, but the plague was still claiming new victims each day, and we lay there coaling for three days.

On the morning of Easter Sunday we entered Manila Bay, passing Cavite and the submarine monument to Admiral Dewey (the Spanish wrecks) on our starboard. We were in Manila about six days.

I saw Dr. Low on the day we left Manila, but only for a few moments—sufficient number of moments, however, for Low to say, "and Brack and Req. and Ruhrah, and all the boys—how are they?" And then we both said "how!", shook hands and went our ways, he to Hospital No. 3, and I to the launch which was just leaving the wharf for the last trip to the U. S. A. T. "Indiana," before she weighed anchor for the southern part of the archipelago. She carried a battalion of the 29th U. S. V. I., which was to take possession of two islands, Marinduque and Mosbate. I was to accompany the expedition and report upon arrival at Iloilo. Dr. Vose, who had been with us on the "Meade," was also on the "Indiana."

The gunboats "Villalobos" and "Helena" and the tug "Baltimore" accompanied us. We were expecting a "scrap," and the boys of the 29th were red hot for it. But when our little fleet dropped anchor in the bay at Brac, Marinduque, a few days later at 6 a. m., the first sight that meet our eye was that of a native running along the beach, and so great was his anxiety that he should be recognized as an "amigo" that, having no white flag at hand, he pulled off his white trousers, and tying them to his paddle, waved them frantically about his head. We made several marches over the island, and on May 1st got under way for the island of Mosbate, further south, having left one company, with Dr. Vose as surgeon, to take care of Marinduque.

At Polanog, Mosbate, we had our first bit of excitement. We

reached the town about daylight, and could make out with glasses an old blockhouse, surrounded by trenches which ran around the crown of the bluff overlooking the bay.

The men were put into the ship's boats and, towed by a launch, started shoreward. We watched and waited. A puff of smoke rose from the blockhouse and was followed by a report that filled the air so that no one could tell where it came from. Of course we thought the fort had opened on us, but when we saw the Filipinos pouring out of the blockhouse and trenches like ants, we knew it was the "Helena's" rapid-fire guns. The men jumped from the boats when the water was yet above their waists and went after the *insurrectos* as if they were after rabbits. The *insurrectos* made one stand, and fired a volley and several scattering shots and then took to their heels in earnest. Not, however, until three of them had been stretched dead among the "Spanish bayonets" and palmetto bushes. We captured a horse, a flag, several *bolos* (large fighting knives) and several prisoners, and leaving three companies to finish the job, proceeded to Iloilo, which place we reached May 7th, having been out from Manila 19 days.

I have been at this post since May 14th, and must confess I am not at all homesick—yet.

Our headquarters are in a native shack, but we have hardwood floors and a thatched roof. We are only a hundred yards from as pretty a bay, and as elegant a bit of beach as one could wish to see, and of course a dip in the surf is the first thing on the programme each day after reveille, which is at 6 a. m.

The village is nestled at the foothills of the highest peaks in the range of mountains which lie along the west coast of Panay, and is almost hidden from view by cocoanut trees, breadfruit trees, banana, palms, etc. The principal native fruits are mangoes, pineapples, cocoanuts and "henfruit." Of the latter about four-thirds float when placed in water.

As I look out the window I see crossing the plaza a cart (with stakes lashed to shafts and passing underneath the axles, for wheels) drawn by a *cavabaa* (water buffalo) and driven by a native, who sits astride the beast, and is clothed with a hat, a "G-string," and implicit faith in heaven. . . .

Sincerely yours,

J. M. LOWREY,

Acting Asst. Surgeon, U. S. A.,

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REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
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Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

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Personal Notes.

DR. J. J. SULLIVAN, '97, spent the year after his graduation at the University of Pennsylvania, graduating there in '98. After passing successfully a competitive examination he was appointed to St. Agnes Hospital, Philadelphia. After spending a year at that institution he located in Scranton, where he is now practicing.

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DR. T. W. PERKINS, '00, who, since graduation has been one of the assistant physicians at the Maryland Hospital for the Insane at Spring Grove, is now an assistant surgeon in the army.

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Personal Notes.

DR. P. H. STULTZ, '95, Bear Creek, Mo., writes: "I suppose you are aware I am doing a country practice. I have all the work I could ask for with yet a growing practice. Am glad to tell people that I graduated at the P. & S. of Baltimore and am proud that she gives a training that enables young men to take their stand in the midst of older heads and yet come out victorious."

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

INTRODUCTORY ADDRESS, COLLEGE OF PHYSICIANS
AND SURGEONS, BALTIMORE, SESSION OF 1900-1901.

BY DR. EDWARD N. BRUSH, PROFESSOR OF PSYCHIATRY.

GENTLEMEN:—I am told, with what degree of truth I am unable to say, that the post of introductory lecturer is held in turn by the successive additions to the faculty. If this be true I am quite sure that in this particular instance you will regret that the chain was not broken and I can only salve your disappointment by promising you something much better next year as there is most excellent material now on hand ready for use.

Assuming that it is because the younger men of the faculty are, in a sense, nearer the young men on the benches and in the class rooms, and I assure you we do feel very near you, and sometimes wish we could sit beside you, I beg to approach the task which is set before me to-night more in the spirit of a fellow-student than that of a teacher. An intimate acquaintance with medical students and some experience, both remote and recent, as a teacher, leads me to expect in you at once a critical, and a kindly considerate audience.

A gruff old professor is said to have exclaimed once, in coming for the first time into the presence of a medical class, "God help you! young gentlemen." At the outset of your medical career, as at any

stage thereof, you can do no better than reverently and sincerely say the same thing, but there is an old saying that the "Lord helps those who help themselves." What preparation have you made? Some of us who are older than you, have been told that a certain state in life "is not by any to be entered into unadvisedly or lightly; but reverently, discreetly, advisedly, soberly and in the fear of God," and in the same manner let us hope you have entered upon the study of medicine.

If you have sought a professional career because you considered it a calling somewhat more dignified and genteel than trade or manufacturing, or because you thought you saw in it a way to position, influence and a competence; if no higher motive, no love of scientific study, no zeal for observation and research, has actuated you, then truly may I echo the remark of the old professor, God help you!

The higher motive, the love for scientific observation, the zeal for study and research, may not have all or any of them been clearly recognized by you, but if these have not been latent or have not had an influence, conscious or unconscious, in moving you to the selection of medicine as your vocation, it is not your vocation. That which you thought was a call was a false and mischievous voice, to which, even now of those either on the threshold or who have entered the temple, I beg you pay no heed.

In a recent article upon the opportunities of the opening century, by a senator of the United States, the writer quotes from the pessimistic talk of a young man as follows:

"The great principles of the law have all been announced, and applied to every conceivable form of human rights and controversy. . . . In invention there may be some improvements on old and present inventions, but there will be no more Edisons, no more Teslas. In medicine we are about on the top of the mountain. In literature the creative and fundamental things have all been done. From now on books will be mere second-hand talk. In statesmanship nothing is left except that common housekeeping which we call administrative government."

The senator goes on to say that this young man's melancholy view

of life is that which he has found crushing the enthusiasm out of most college students he has met.

If the senator himself has not taken a too melancholy view of the ideas of the college students he has met, then he has been singularly unfortunate I believe in meeting his men. The college men whom I know, or whom I have known in the last twenty years and more, have certainly not as a class, or in any very large number, taken that view. I know as you know, as you have probably experienced among your associates, if not in your own life, that there comes a time to many young men when a certain pessimism seems a good thing to hold and with which to color one's views of life. The young undergraduate is very apt to talk of the good old days of the past and berate the decadence of manners and morals and the lack of opportunity of the present. Most of these get well over it by the time they are ready to enter upon real life and choose a career, but some remain purblind and go all their days unconscious of the opportunities all about them, bemoaning the past, bewailing the present.

You, young men, do not, I am confident, belong to this class. If there be among you any who are inclined to the belief that their lives have fallen in evil times I commend to them the wise words of a Roman philosopher who wrote in the first century of the Christian Era, but whose words are very applicable to some in these days. "We must guard" he says, "against letting blame fall on our own age. This has always been the complaint of our ancestors, that manners have been corrupted, that vice reigns, that human life is deteriorating and falling into every kind of wickedness. We lament in the same strain and our descendants will do the same after us."

If law has no new principles to establish; if decision and precedent cover all matters of human controversy or human right; if theologians have come to fixed and unchangeable opinions as to man's relations with his Maker and his responsibility both as his own and his brother's keeper; if invention has reached its limit, and statesmen having no new and lofty principles to urge, shall satisfy themselves with the division of the spoils of party victory, and the gains of "practical politics," let us not admit that the science and art of medicine have reached the zenith of their glory.

Were we to accept this view it would at once paralyze all effort, deaden all ambition.

“This life were brutish did we not sometimes
Have intimation clear of wider scope,
Hints of occasion infinite, to keep
The soul alert with noble discontent.”

Marvelous as have been the discoveries of the century which is just closing, the men who were alive at its opening were as much justified, nay more so, than are we, in saying that there was scant opportunity for doing great work, for making grand discoveries. We have the advantage of the very remarkable material progress of the past century and its wonderful application of some of the forces of nature, not only to man's material benefit, but to his use in further solving the many unsolved mysteries of nature.

Professor W. K. Brooks, than whom few men have done more in scientific research, said in a recent address on Scientific Laboratories: “The scientific men of the nineteenth century do not fear for their successors. They are confident that you will not be found wanting in the high qualities that win success, although the road ahead of us looks very much like that over which we have come, with a few smooth, easy places, and many that are rough and hard.” Observe that Professor Brooks says there are many places which are rough and hard before the student of science in the coming century. He very wisely utters a note of warning to those of you who may be inclined to rely too much upon the superior advantages which you enjoy. He says: “But if you take it for granted that you are destined for great things because you have great opportunities and great advantages your end will be disappointment and decay; for you are destined to do nothing except what you determine to do, and fight for.”

His words sound very much like those of one of the most famous educators of young men of the past fifty years, addressed in his final charge to a class of young men of whom I had the good fortune to be one. “Young gentlemen” he said, “some of you will, I fear, think that opportunity awaits the man, and will wait the opportunity.

Some of you will 'grasp the skirts of happy chance, and breast the blows of circumstance.' Some of you will make chance and circumstance subservient to your determination to do the work before you in all honesty and loyalty to yourselves and to your fellowmen. Some of you will make your mark in the world, some of you will never be heard of again."

I repeat, do not, young gentlemen, be influenced by opinions similar to those quoted by the senator. Never in the history of the world were there greater opportunities for good, painstaking work. It is your privilege to seize the opportunities. But opportunity, chance, will not do the work.

"Chance sends the breeze,
But if the pilot slumber at the helm
The very wind that wafts us toward the port
May dash us on the shelves."

As students of science, the world, and more especially your chosen profession, will expect that you add something to the sum of human knowledge, which is, as you know, the "amassed thought and experience of innumerable minds."

In order to do this you must be careful, painstaking, above all, honest observers. To be these you must learn how to observe, and to this end you must apply not only all that is taught you here, but you will realize the value of a sound training, a liberal education before coming here.

Bacon said long ago: "God forbid that we should give out a dream of our own imagination for a pattern of the world."

Unless you have been taught how to observe and compare, how to weigh the value of evidence, you will stand in great danger of giving out a dream of your own imagination for some new fact in science; or escaping that, you may fall upon something which you think is new and give it to the world as your own, when a broader culture would have saved you the error.

Joseph Henry Green in quoting one of the maxims of Strabo: "The value of a poet is bound up with that of a man. He cannot be a good poet who is not a good man," says, "I anticipate no objec-

tion when I state that the process for attaining or approximating this great moral result, constitutes in its scope or end a liberal education."

To no profession of the present day is this more applicable than to the profession of medicine; to no student is it more necessary than to the student of medicine.

Bryant has said:

"To him who in the love of nature holds
Communion with her visible forms she speaks
A various language."

Professor Brooks, whom I have already quoted, says that "the scientific method of acquiring knowledge is to listen to the language of nature."

To listen to this language with an understanding ear, to be able to correctly interpret its teachings requires in medicine, as in all departments of science, a liberal education.

This language can only be clearly heard or correctly interpreted by a mind, trained to careful observation, to thoughtful experiment, from whence all true experience.

I am aware that there is in the profession a prejudice, which I am happy to say is growing less and less marked, against what are called the speculative class in medicine. Men who are supposed only to suggest hypotheses and evolve theories. The so-called practical men are wont to sneer at those who speculate, forgetting, possibly in ignorance of the origin of the word, that the true speculator in science is one who holds up the mirror to nature, is one who sees.

In one of his admirable essays, that on the sky, Tyndall says:

"In the house of science are many mansions, occupied by tenants of diverse kinds. Some of them execute with painstaking fidelity the useful work of observation, recording from day to day the aspects of nature, or the indications of instruments devised to reveal her ways. Others there are who add to this capacity for observation a power over the language of experiment, by means of which they put questions to nature, and receive from her intelligible replies. There is, again, a third class of minds that cannot rest content with observation and experiment, whose love of causal unity tempts them per-

petually to break through the limitations of the senses, and to seek beyond them the roots and reasons of the phenomena which the observer and the experimenter record.

"To such spirits adventurous and firm, we are indebted for our deeper knowledge of the methods by which the physical universe is ordered and ruled." He continues: "In his efforts to cross the common bourne of the known and the unknown, the effective force of the man of science must depend, to a great extent, upon his acquired knowledge." Your effective force, gentlemen, as students of medicine, will depend upon your acquired knowledge. I do not mean the knowledge which you may acquire here or elsewhere of medical science, but the general knowledge which you bring to your aid in acquiring special knowledge.

The broader your culture, the more varied your intelligence, the greater the number of points at which you come in contact with the world of letters and science, the more superior will be your advantages, other things being equal. "The man who has been trained to think upon one subject or for one subject only, will never be a good judge of that one; whereas the enlargement of his circle gives him increased knowledge and power in a rapidly increasing ratio. So much do ideas act, not as solitary units, but by grouping and combination. . . . Judgment lives, as it were, by comparison and discrimination."

The problems of medical science yet to be solved afford as great opportunities to-day as did those which confronted our ancestors.

In anatomy there are many yet unexplored fields and especially is this true of the anatomy of the nervous system. It follows as a natural corollary that equal opportunities lie before the student of physiology, for it is one thing to demonstrate the structure of a part, another to establish its function. Chemistry and especially physiological chemistry affords ample scope for the most energetic and enthusiastic student; and from researches in that department we may naturally expect, judging from the very recent past, to achieve results which shall add to the resources of *materia medica* or make new and more accurate uses of old materials.

All of these studies will but naturally in the future modify not only the theory but the practice of medicine and surgery. In surgery Anæsthesia which robbed the operation room of its terrors both to the patient and the surgeon, is of so recent application, that I am able to recall that the anæsthetic was administered to the patient upon whom I made my first important operation, an exsection of the lower end of the femur, by a physician who had as a student seen in the amphitheater of the Massachusetts General Hospital the first operation under ether. As for that equally important modification of the surgeon's art, antisepsis, its inception, development and application are within the memory, nay indeed, the experience of all of the older surgeons of the day. To it are due the remarkable, almost miraculous, achievements of the general and the special surgeon to-day, and the increased safety of the parturient woman.

Who shall say, however, that either anæsthesia or antisepsis is not yet susceptible of being made more safe and easy of application on the one hand or more certain on the other?

Bacteriology, that entrancing and wonderful study of the infinitely small and infinitely powerful and omnipresent worker for mischief or good, "stands tiptoe on the misty mountain tops" in the dawn of the new century. What lies behind those mountains, what is enshrouded in that mist, who shall say.

It is in its achievements in preventive medicine that the profession has perhaps produced results which will probably appeal more strongly than anything else to the laity.

Smallpox which at the opening of the century was one of the most common diseases has in many communities been practically stamped out. Typhoid fever in those localities where a proper supervision of water supply and rigid hygienic regulations are enforced, is gradually meeting the same fate, and so of scarlet fever, diphtheria and other diseases of whose specific poison, or the means of conveying it, we have definite knowledge.

Preventive inoculation except in smallpox is in its infancy. The opportunities for good work both for science and humanity in this direction cannot be measured.

Tuberculosis, the white death, that scourge of civilization will yet be controlled, indeed its death rate is being already perceptibly diminished, and the lives of its victims prolonged by the application of what would seem the most obvious hygienic principles.

The whole broad field of hygiene is open before you, gentlemen. Here and there energetic efforts have met their reward, but whole states and innumerable isolated communities have yet to learn the gospel of pure water, pure air, clean surroundings, proper food and good cooking. If in all other departments of medicine I could say this evening that all the advance possible had been made, in state medicine alone, you would find work enough to occupy all of your energy.

(To be continued.)

ON THE TREATMENT OF DENDRITIC KERATITIS AND OF MARGINAL ULCER OF THE CORNEA WITH TINCTURE OF IODINE.

BY DR. HARRY FRIEDENWALD, '86, BALTIMORE, MD.

(READ BEFORE THE AMERICAN OPHTHALMOLOGICAL SOCIETY, MAY 2, 1900.)

My experience for a number of years in the treatment of dendritic keratitis and of superficial rodent ulcer of the cornea was most unsatisfactory. Many cases were so protracted in their course that there was abundant opportunity for trying the ordinary remedies, all with more or less unsatisfactory result. The inflammation finally subsided in many cases because the disease had run its course and not as a result of the remedies employed. Among these atropin, eserine, bichloride of mercury, formaldehyde in solutions and ointments of iodoform, iodol, aristol, etc., are to be mentioned.¹

Even the actual and the galvanic cautery often failed to prevent extension of the ulcer. In the belief that others have had the same unpleasant experiences I am led to make the following communication, for I no longer look upon these cases with the dread of a long

¹ I have recently learnt that Swanzy uses absolute alcohol and claims that this rapidly cures the affection.

course of inefficient treatment resulting in great loss of vision from corneal opacities.

In August, 1898, Mr. G. came under treatment for beginning dendritic keratitis. There was a small horizontal linear furrow on the inner half of the right cornea near the periphery and pointing toward the lower edge of the pupil. Atropin and iodoform ointment were used with good effect apparently, but in a few days the ulcer reached the lower margin of the pupil and one fine branch upwards indicated that it was about to traverse the center of the pupil. I determined, therefore, not to delay any further and wiped the entire ulcer with tincture of iodine. On the next day, finding that this remedy had caused little irritation or pain I repeated the application. On the following day the cornea was studded with fine points which rapidly developed into filaments, typical of filamentous keratitis. They were wiped off with cotton and touched with a three-grain solution of nitrate of silver and did not recur. The ulcer had in the meantime disappeared and it left no trace. The vision of this eye is almost perfect.

The very favorable result of the treatment in this case induced me to try the same in others and I have employed it in more than twenty-five cases of dendritic and rodent ulcers. It has never failed to bring relief. Not only was the further spreading of the ulcer prevented, but its peculiar character was changed to that of a simple abrasion of the corneal epithelium which usually disappeared in a very few days. Nor have untoward symptoms ever manifested themselves excepting the appearance of filamentous keratitis in the one case mentioned above.

Method of application.—A bit of absorbent cotton is wrapped firmly about a fine wood tooth-pick, so as to form a narrow, firm swab. This is dipped into the tincture of iodine and the excess allowed to drop off. The eye having been prepared by instilling cocain and a drop of fluorescein, the ulcerated area is thoroughly scrubbed until a distinct brown discoloration of the tissues is seen. The neighboring epithelium is very much loosened and curls up in all directions. It is important to touch this and especially the minute infiltrations

seen a millimeter or two away from the main line of ulceration; for the progress of the disease is usually this, that after these fine infiltrations are observed the furrowed ulceration soon makes its appearance. The only error which is likely to be made is to apply the iodine too cautiously, for I have never seen any ill effect from its being used too freely. Since I have become bolder in using it, it is rare that I need to make a second application. More than twice I have not applied it in any one case—it was never necessary.

The application is usually followed by some pain, lasting for a few hours, though I have sometimes been told by the patients that they suffered little pain. The eye is bandaged and an ointment of boric acid, iodoI or the like applied. The bandage can usually be dispensed with after a day or two, though it may be well to use the ointment a few days longer.

I should like to state here that I have been able to definitely associate dendritic keratitis with malaria in but a single case. The patient was treated with tincture of iodine and was well on the second day following. She was not, however cured of the malaria for some time.

In order to determine the amount of damage that it is possible to do with the too-abundant application of the tincture of iodine, I applied it to the eye of a rabbit. A healthy cornea was scrubbed with a fine swab saturated with the tincture until half the cornea was denuded of its epithelium and then the rubbing was continued until this entire region was stained a deep brown. A little reaction followed and this portion of the cornea became the seat of a gray infiltration but this was gradually absorbed and disappeared entirely in a few weeks.

It may surprise some to hear that I have treated such a large number of cases of dendritic keratitis in so short a period, for it is usually considered a rare condition. I ascribe my large number to the fact that I am in the habit of examining all corneal lesions with fluorescein and the loupe. In a number of cases seen with colleagues I have thus been able to determine the true character of an ulcer, previously not recognized. Basing my statement, therefore, on experience, I

desire to say that many cases looked upon as simple ulcers or as herpetic are in reality dendritic.

An important reason for the careful differentiation of the various forms of keratitis is that the treatment I have given for dendritic keratitis is without effect in phlyctenular, serpiginous or other so-called infected ulcers with the exception of marginal ulcers of which I shall now speak.

I have notes of three severe cases of marginal crescentic ulcers which I have treated with tincture of iodine, with rapid and complete recovery in all. In two of these the membrane of Descemet were laid bare and perforation imminent. Two of these cases had been treated elsewhere for some time. The application of tincture of iodine was followed by rapid abatement of all the symptoms and with immediate improvement of the appearance of the ulcer.

Three cases may appear as scarcely sufficient evidence of the efficiency of the method. The change in the condition, however, was so striking that those who saw the cases agreed that in this disease as in dendritic keratitis, tincture of iodine may be considered as a specific remedy upon which we may rely with confidence.

During the winter of '98 and '99 Dr. Hiram Woods presented a case of dendritic keratitis, which had resisted all treatment, before the Ophthalmological and Otological Society. Upon my suggestion he employed the tincture of iodine and he has since told me that in this and in other similar cases in which he employed it its effect was most satisfactory.

Dr. Russell Murdoch has likewise employed this treatment in a number of cases of dendritic keratitis and he has permitted me to say that his experience has borne out my statements.

I do not desire to make it appear that I am introducing iodine in the treatment of diseases of the eye, for many of our works refer to its having been used. It is my purpose to define those cases in which it may be used with advantage, and in which its usefulness cannot be overstated.

A CASE OF CANCER OF THE ESOPHAGUS WITH PERFORATION INTO THE LEFT PLEURAL CAVITY; DEATH FROM PYOPNEUMOTHORAX.

By DR. JULIUS FRIEDENWALD, '90.

(PRESENTED AT THE MEETING OF THE AMERICAN GASTRO-ENTEROLOGICAL ASSOCIATION, AT WASHINGTON, JUNE 2, 1900.)

Mrs. J. H., married, aged thirty-one years, first consulted me on October 15, 1899. Her family history was good. Her father had died of an accident; her mother is still living, as are likewise all of her brothers and sisters. She had always been in good health until the end of July, when difficulty in deglutition was first noted. This difficulty was at first noted only with solid food, and finally about the middle of September there was absolute inability to swallow solids, while even liquids were now passed into the stomach with difficulty. Recently the act of deglutition was accompanied with great pain; there was frequent regurgitation of mucus, but never of blood; there were constant eructations, and there was obstinate constipation.

On examination, the patient is found to be a well-nourished woman, with well-developed muscles; glands are nowhere enlarged; the mucous membranes are red; the heart and lungs normal; the examination of the abdomen is negative. The blood examination shows 5,000,000 red blood corpuscles and 10,000 white; the urine is normal. In introducing the soft tube a resistance was felt, through which the tube could not be passed. When measured this was found to be 43 cm. from the teeth. Various sizes of soft rubber tubes were tried, but could not be passed through the stricture. The hard rubber tubes were then introduced. The large-sized bougies could not be passed into the stomach, but those of small size were passed without difficulty. The obstruction was constantly located at from 42 to 45 cm. from the teeth. The second deglutition murmur was delayed often to forty seconds, and at times was entirely absent.

The patient was seen frequently, and constantly complained of pain in swallowing, and of great difficulty at times in getting even

the smallest quantity of milk into the stomach. The small-sized bougies were now (November 15, 1899) passed with great difficulty, and at times could not be passed at all. Dr. Osler saw the patient with me on November 18, and advised gradual dilatation with olivary bougies. This was practiced almost daily, but without avail; even the smallest olive could not be passed through the stricture at times.

The patient was yet in good general health, and was not cachectic, and there were no enlarged glands.

A hard rubber stomach tube of very small caliber was given the patient, through which milk could be passed into the stomach on those days on which she was unable to swallow anything. On December 2, 1899, Dr. Osler again saw the patient with me, and we then concluded to have a gastrostomy performed.

The patient was admitted to the Union Protestant Infirmary on December 11, 1899, under the care of Dr. J. M. T. Finney. On December 12, 1899, Dr. Finney attempted to pass a small-sized bougie under ether anesthesia, but was unable to pass it into the stomach; a gastrostomy was then performed, and a small olive sound passed from below, when an obstruction was discovered 10 cm. above the cardiac orifice of the stomach; the bougie was passed through the strictured area, a string was attached to it and withdrawn, and larger sounds were then drawn through from below attached to the cord, until the largest passed with ease. In passing the first or second sound something was felt to give way. The stomach was sutured to the abdominal wall and closed.

The patient did well until the morning of December 16, 1899. Her temperature had remained between 99° and 101°, and her pulse 100 to 108, and she was able to retain small quantities of egg albumen, milk and broth. On the morning of December 16 she complained of intense pain in the left chest. There was marked dyspnea, and during the afternoon the temperature rose to 103.4° and the pulse to 140. Dr. Pancoast, the resident physician, at once discovered a pyopneumothorax in the left chest, and aspirated a quart of brownish pus.

At 12 A. M. the next morning Dr. Finney resected a rib at the

angle of the scapulæ, when a large amount of foul-smelling pus was evacuated; a drainage tube was introduced. The patient never rallied; her temperature rose to 104° and her pulse to 160, and she died early the same morning.

Only a limited autopsy through the back wall was permitted, and the finger was passed from this opening into the esophagus through the perforation. A portion of the esophagus containing the cancer was removed. It consisted of an oblong ulcerated mass, the largest diameter, $1\frac{1}{2}$ cm. in length, being longitudinal to the esophagus, its shortest diameter being 0.5 cm. in length. The circumference of the ulcer was very hard and indurated, the base soft and dipping deeply into the mucosa; along the inferior surface of the ulcer the opening was found indicating the point of perforation. In placing the esophagus in its normal position an almost complete obstruction is presented at the point of stricture. Microscopically, the mass was found to be an adeno-carcinoma.

This case is interesting as showing one of the rather rare results of cancer of the esophagus.

I am indebted to Dr. Pancoast, resident physician of the Union Protestant Infirmary, for the report of the case while the patient was at the hospital, as well as for the post-mortem examination.

A CASE OF COMPLETE INVERSION AND PROLAPSUS OF THE UTERUS.

By DR. J. W. PICKEL, '84.

On June 13, 1893, I was called at 8.30 A. M. to see Mrs. R. in labor. She was German, stout of build, married five years. She had had two miscarriages and one still birth; the last child is living, healthy, aged nineteen months. Patient has suffered for the last few years with prolapsus uteri. Digital examination showed the os well dilated; presentation V. R. O. A. Pains were irregular, infrequent and inefficient. At 9 A. M. I gave eight grains of quinine. This was all the medicine she had until the child was born. In half

an hour the pains were stronger and more frequent. The child was born at 12.15 P. M. As the head was passing the vulva there came a powerful expulsive pain which sent the child swiftly through my hands, and it lay on the bed as far away as the cord would let it go. The child was of medium size and well developed.

Pains to expel the placenta began promptly. With my hand placed gently across the abdomen I noticed that the fundus uteri was uncommonly broad, and at each contraction it became smaller unusually fast, but I still suspected nothing uncommon. The placenta could now be felt in the vagina and, as I made gentle traction on the cord to lift it out, there came a strong expulsive contraction and the uterus inside the placenta lay fully six inches outside the vulva. I rapidly stripped off the placenta and membranes and attempted to replace the womb; but as the patient's suffering was terrible, and having no help but the husband, I wrapped the uterus in a clean towel and gave a hypodermic of morphine. By this time the inverted uterus was too large to pass back through the vulva, but with firm and continued pressure with my hands the size was reduced so that it went back easily into the vagina. It being too tender for further manipulation, I had to send three miles and a half for an assistant.

The loss of blood was small, the suffering intense, but the shock not great; pulse 96, breathing rapid, swimming in the head.

The assistant arrived about 2 P. M. Chloroform anæsthesia. A hand was introduced into the vagina, the uterus firmly grasped and pushed with counter-pressure by the other hand against the cervix, which could be felt through the abdominal wall as a hard ring about one inch and a half in diameter. This accomplished nothing. Then lateral taxis was made. This also did no good. I then folded my fingers into a cone and made steady pressure on the inverted fundus, at the same time using the other hand in the same manner; thus pushing the abdominal wall into the os and dilating it. The right hand in this way readily carried the fundus through the cervix, and the entire uterus to its normal position. My hand was left in the uterus until a hypodermic of normal liquid ergot was given and firm contraction obtained. An intra-uterine douche of boiled water and

bichloride 1 to 4000, as warm as could be borne, was given with the Jamison irrigator. These douches were repeated daily for the three following days.

Patient made an excellent recovery and suffered less, she said, than during her previous confinements. Her temperature rose to 101° F. on the third day with some delirium, which readily gave way to purgatives and quinine. Since her confinement the prolapsed uterus has been kept up and she has been quite comfortable with a Hodge pessary.

It may seem that this trouble should have been discovered and prevented but, as I had never met with such an accident in over five hundred confinements, and as it is said to occur only once in a hundred and forty thousand deliveries, coming on so suddenly it caught me off my guard.

Here the cause of inversion was plainly the sudden jerk on the cord given by the rapid expulsion of the child. It will also be noticed that stripping off the placenta and membranes did not cause hæmorrhage. The three methods usually recommended to restore the inverted uterus were tried, with results in favor of replacing the fundus first.

Crystal City, Mo.

POSTPARTUM PUERPERAL ECLAMPSIA: REPORT OF A CASE.

BY DR. A. A. SHAWKEY, '00.

Mrs. E. S., age 22, primipara. First seen June 28, 1900. On arriving at the home of the patient I learned that she had given birth to a normal child, two hours before, under management of a midwife; and that half an hour after the termination of labor, convulsions had set in and were recurring regularly every thirty minutes, the fourth one occurring a few minutes after my arrival. Immediately upon my arrival I had dispatched for chloral hydrate and Norwood's tincture of veratrum viride, but as my messenger had not yet returned when the convulsion came on, I administered morphine $\frac{1}{4}$ gr. and

atropine $\frac{1}{120}$ gr. hypodermically, had the patient wrapped in blankets, producing free perspiration, and gave 2 minims of croton oil by the mouth. The latter proving inefficient, was supplemented, in due time, with elaterin in doses of $\frac{1}{20}$ gr. Upon the arrival of the chloral I ordered 30 grs. by the rectum, to be repeated every hour.

The patient responded to the treatment so promptly that I did not use the veratrum until an hour and fifteen minutes later, when there was another recurrence of the convulsions, during which I administered 10 minims of the veratrum hypodermically, continuing the chloral but reducing the dose and lengthening the interval after the fourth dose.

There was no further recurrence of the convulsions and the patient proceeded to a rapid and uninterrupted recovery.

As the patient had not been under observation, I am unable to give any historical data beyond that of marked swelling of feet and legs during the latter half of the period of gestation, and some other more or less indefinite indications of nephritis.

Urinalysis has been impossible, as my requests for samples have not been granted.

Since the close of the puerperium the patient has enjoyed very good health, with no apparent indications of kidney trouble.

Charleston, W. Va., August 22, 1900.

TWO CASES OF PUERPERAL ECLAMPSIA.

BY DR. S. WALTER WOODYARD, '91.

Having had the responsibility of treating two cases of puerperal eclampsia (at term), during the past year, I will make a brief report of them. I will state in the beginning that I claim nothing original in the line of treatment pursued.

CASE 1. Mrs. C., æt. 23; primipara; robust and well developed; had been in labor 18 hours when I was called; had taken a few doses of morphia administered by an itinerant physician. When I arrived the patient was in the most horrible convulsions I have ever witnessed, her features being so distorted that her friends who arrived with

me did not recognize her. Knowing that she was a very robust woman, I at once opened the median basilic vein and let about 16 ounces of blood flow therefrom. The circulation continuing very rapid and bounding, I injected into her arm 25 drops of tincture veratrum viride (U. S. P.), which soon lowered her circulation to 80 beats per minute. On making vaginal examination I found the os dilated about the size of a silver half dollar and very soft. I at once set about dilating the os manually, during which the patient had another convulsion. As the circulation was still 80 and bounding, I administered hypodermically 12 drops of veratrum which soon lowered the circulation to 60. The os at this time being sufficiently dilated to apply the forceps, I proceeded to deliver the child, which was accomplished without further trouble, the child being asphyxiated to such a degree that efforts to resuscitate it were of no avail. Patient remained unconscious for twenty-four hours after delivery, bowels acted freely from salines next morning, but the urine had to be removed with catheter for three days. No elevation of temperature, but had a weak circulation for two weeks. Patient was placed upon the usual tonics with strophanthus, making an uninterrupted recovery.

CASE II. Mrs. M., æt. 19, patient of Dr. McL., primipara. Had been in labor twelve hours when I was called. Had had twenty-one convulsions, all told, when I arrived. The convulsions had been partially controlled by the use of inhalations of chloroform. The physician in attendance concurring with me, we administered hypodermically twenty-five drops of tincture veratrum viride which soon brought the circulation down to fifty-five per minute. The os was relaxed and was dilated manually and forceps applied. Without further trouble a living child was delivered. This patient had two convulsions after delivery, regained consciousness the next day, and with the exception of a weak circulation, passed through a normal puerperium.

NOTES: 1st. Albumen in large quantities was present in the urine of both patients. 2d. No nausea was occasioned by the use of the veratrum.

Greenville, Tenn.

TYPHOID FEVER IN AN INFANT EIGHTEEN MONTHS OLD; RECOVERY.

BY DR. A. SAMUELS, '98.

Typhoid fever in infants under two years of age is of comparatively rare occurrence, Holt having never seen a case. Northrup did not meet with a single case in two thousand autopsies at the New York Foundling Asylum. In epidemics, cases in infants under two years old have been observed. In the epidemic which occurred in Montclair, New Jersey, in 1894, of 115 cases, three were in children under two years; in Stamford, Connecticut, in 1895, of 406 cases, four were in children under two years.

Its atypical course and the absence of the common symptoms, together with continued fever of unknown origin, render the diagnosis difficult, but with the laboratory means now at hand, few cases, if any, should pass unrecognized. Unboiled drinking water given to sucklings is no doubt the direct carrier of the infection.

The mildness of the fever, the absence of the common fatal complications—perforation and hæmorrhage—and the low mortality render it a less dreaded disease than typhoid fever in adults. The case I herewith report is of more than usual interest for these reasons:

1. The age of the patient.
2. The duration and severity of the fever, which ranged between 103° and 105° F., and lasted twenty days.
3. The entire absence of the common symptoms of typhoid fever.
4. The extreme anæmia and aphasia as complications.

Unfortunately, I did not see the case until the tenth day, and no satisfactory history of the onset could be obtained.

M. M., a girl, aged eighteen months, of German parentage. She had been nursed by her mother until the illness began. Small quantities of unboiled water were given between the nursing periods.

Physical Examination.—Infant well nourished and developed; pale and anæmic; countenance dull; does not cry when approached; skin hot and dry; no eruption; slight retraction of the head; tongue coated; ten teeth; fauces clear; breath heavy and odorous; appetite poor; bowels constipated; temperature in the rectum, 103° F.; pulse, 150; respirations, 45; lungs clear; breathing quick; no râles; heart's

action quick and weak; sounds clear; liver normal; spleen enlarged; abdomen tympanitic; no appreciable tenderness; carphology and subsultus tendinum in a modified form was present.

Blood Examination.—Red corpuscles, 1,500,000; white, 35,000; hæmoglobin, 30. Widal reaction; no plasmodia malarie.

Urine: quantity passed in twenty-four hours, ninety cubic centimeters; highly colored; of a strong odor; Diazo reaction neutral; specific gravity, 1.032; a trace of albumin; no casts; uric acid and triple phosphates. Cultures from fæces showed Eberth's bacillus.

The treatment consisted in the use of the cold pack, and it was used whenever the temperature reached 102.5° F. or over; nursing was discontinued and Eskay's albuminized food substituted. The infant did not object to the bottle, I suppose on account of the extreme prostration. Cold lemonade made with sterilized water was given in the intervals between bottles. It was readily taken, and the refrigerant properties were of value in reducing the fever and relieving thirst; ninety cubic centimeters would reduce the temperature from half a degree to a degree. Olive-oil enemata were given for the constipation, which lasted throughout the disease; no antipyretics were given. The temperature, after lasting for twenty days, as before stated, dropped by crisis; the evening before it had been 103.5° F.

Convalescence was rapid and uninterrupted. Before the child's illness monosyllabic words had been uttered. During the last week of her illness and for three weeks after it none whatever were uttered. Hearing and sight were good, and walking was fairly well established.

At the present time, ten weeks after her recovery, the aphasia has entirely disappeared.

REFERENCES.

- Holt. *Diseases of Infancy and Childhood.*
 Osler. *Principles and Practice of Medicine.*
 Morse. *Boston Medical and Surgical Journal*, January 27, 1896.

TYPHOID FEVER, PERFORATION, RECOVERY; SECOND PERFORATION, LAPAROTOMY WITH AUTOPSY.

BY DR. H. LOUIS STICK, '00.

Mr. G. F. K., a male patient; widower; brakeman, 32 years old; was admitted to the Baltimore City Hospital, June 18, 1900, on account of loss of strength and weight; high fever; much accelerated pulse; flushed face and extreme weakness.

The family history is negative. In early life he had whooping-cough, mumps, measles, chicken-pox and scarlet fever; pneumonia at age of 9 years. Appendicitis with peritonitis, which attack lasted for 11 weeks, after which time he fully recovered.

Present disease began on May 6, 1900. Constipation was noted with frontal headache, soreness all over; three weeks later he became so weak that he was unable to be about. About this time he was taken with chills—feeling at times somewhat better.

On June 18, at 5.30 P. M., his temperature was 105° ; pulse 110 and respirations 35; complained of severe lumbar pains; severe frontal headache and of being very weak and nervous.

Physical Examination.—Inspection: eyes had a distant expression; conjunctivæ showed anæmia.

Lips were dry and parched; tongue heavily coated and dry. His skin was dry and very hot.

Abdomen was somewhat distended, which was most marked on the right side over region of McBurney's point, and was somewhat tympanitic on percussion.

Several rose spots could be detected over the upper anterior portion of the abdomen.

There was a marked capillary enlargement along the lower thoracic region, extending from a point about 4 in. to the left of sternum upwards and to the right, ending in the middle of the axillary region corresponding to the sixth intercostal space. The area of hepatic dullness was somewhat enlarged; he experienced some pain on slight pressure in lower part of this region, $\frac{3}{4}$ inch below margin of ribs.

The abdominal muscles were more rigid on the right side than the left.

The spleen could be easily palpated.

The lungs were normal. The cardiac area was somewhat distended to the left. An accentuated second sound was detected at apex.

Appetite was very poor; bowels were very loose; micturition was normal.

Quinine sulph. gr. xv were given at 6 P. M.; temperature at 12 midnight was 104° . A sponge bath was given which reduced temperature within 50 min. to 100° .

June 19. Temperature at 8 P. M. was 106° and pulse 98.

Patient had about fifteen stools during past 24 hours. Splenic area enlarged and spleen easily palpable.

Rose spots were more numerous on abdomen, especially about the umbilicus.

Widal reaction was positive.

The urine gave a positive diazo reaction.

June 20, 3d day. Rose spots were more numerous: rigidity of right abdominal muscles was more marked; pulse was soft, but not dicrotic. Lips very dry; tongue was heavily coated. Had three sponge baths during this day. The temperature at 8 P. M. was 104° , a sponge bath reduced it to 100° . Pulse 100. Slept very little all day.

4th day. Patient seemed to be much weaker; very nervous and uneasy; nervous twitching of the muscles of face, arms, and legs. During the afternoon he became unable to speak above a whisper. He had three sponge baths during the day.

5th day. Patient was very nervous and much weaker. Complained of much pain in abdomen, which was somewhat tympanitic on percussion; patient somewhat nauseated; face very much flushed; rose spots less numerous; temperature remained below 102° until 4 P. M. when the thermometer registered $105\frac{5}{10}^{\circ}$; a bath reduced it to $102\frac{6}{10}^{\circ}$, but by 8 P. M. after another bath it was 100° ; at 12 midnight it was 104° , but bath reduced it two degrees.

6th and 7th days. All the symptoms more marked; temperature remained 102° for 36 hours, when at 4 A. M. March 26, 1900, it dropped to 98° ; at 4 P. M. it was 102° and by 7 P. M. it was 104° and pulse 120; by 9 o'clock it dropped to 102, no bath being given.

Patient did not sleep during the past 36 hours; weakness seemed to be more marked.

8th day, June 27, A. M. General condition somewhat improved. Respirations 30; pulse 112, and temperature 101° . Patient was very weak; abdomen soft, not distended; only on deep palpation was a sense of resistance made out in the right ileocæcal region. This condition remained the same until 7 o'clock P. M., when abdomen became much distended; the temperature went up to $104\frac{3}{10}^{\circ}$; the pulse became thready; aspect was that of shock.

Laparotomy at 8 P. M. by Dr. Trimble. The abdomen was opened over region of cæcum.

The intestines were found to be firmly adherent to the abdominal wall by comparatively old adhesions; intestines ruptured at this place while being manipulated.

Two inches above this place a recent perforation was found which was closed.

The abdomen was flushed with a normal saline solution.

700 cc. of salt solution was used subcutaneously during operation.

The intestines were injected and found to be of most recent infection.

The patient died four hours later of shock.

Autopsy.—At autopsy June 28, 1900, which was only partial, the cæcum was found to contain three (3) deep ulcerations. One, just at point of appendix, was in process of healing. This healing caused the intestines to be bound to the abdominal wall and it was these adhesions that were ruptured during the operation.

The second ulcer showed a clear perforation into the abdomen with no adhesions.

Signs of inflammation of the appendix vermiformis were perceptible.

Numerous ulcerations of the Pylers patches were found in the ileum.

Interesting points: History of appendicitis, perforation and healing, leucocytosis from first perforation, second perforation, prompt operation.

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THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

PUS IN THE PELVIS.

The quantity of pus in pelvic abscesses varies from a few drops to several pints. The abscess may be either acute or chronic. When the collection of pus is large, the best method of evacuating it is through the vagina. Beginning just behind the cervix a long but not deep incision is made in the long axis of the posterior vaginal wall. By dissecting with the fingers, occasionally aided by some blunt instrument, the opening is carried into the pus cavity. The opening should be enlarged by the fingers until three fingers can be admitted. Then after the pus has been drained out without irrigation the cavity is packed with gauze. If there is no rise of temperature to indicate obstruction to drainage the gauze can be left in position four or five days. Often after this all that is necessary is a vaginal douche daily. In the chronic cases after the gauze is removed it is best to insert a flexible rubber drainage tube. This tube should be removed and the cavity irrigated through a soft rubber catheter daily until completely healed.

This operation commends itself on account of its safety and simplicity. By keeping the incision in the median line no vessels of importance are cut. By continuing the dissection with the fingers danger to the ureters, uterine arteries and intestines is avoided. The mortality from the operation is practically nothing. The results are

excellent. The vast majority are completely cured. In those not completely cured an exceedingly dangerous abdominal operation is converted into a comparatively safe one.

W. S. G.

Personal Notes.

DR. FRED. E. LILLY, '90, died at Merced, California, last November from a septic infection of the hand contracted while performing an operation.

DR. JOHN C. MORFIT, '95, of St. Louis, was married to Miss Josephine H. Nations of Kansas City, Mo., Sept. 17. The doctor and Mrs. Morfit spent the latter part of September in Baltimore.

DR. L. R. LEITH, '93, Exeter, Mo., writes: "I came west from Virginia in '95, practiced two years in Indian Territory, married a Missouri lady in '97 and am now located at Exeter, where I shall continue to practice."

DR. J. C. FRAZIER, '99, Buffalo, W. Va., writes: "I took the State Board July 9 and 10, and passed all right. Three P. & S. men took the examination; all passed with good grades. Leahy is about as usual, he went from here to Fairmont, W. Va., to locate."

DR. S. H. ALLEN, '90, of Provo, Utah, writes: "I have just operated upon two cases of appendicitis; a boy of 13 and a man of 30; both are doing well; also an ovariectomy which is doing well. The case followed a salpingitis two years ago. The tube and ovary were adherent to the side of the pelvis and a loop of gut was adherent to the fundus of the uterus.

"Robison and I did a strangulated hernia operation on a woman of 64 yrs. yesterday.

"Taylor and I did an empyema on a boy of 5 yrs. to-day. Last Friday I removed half of the right side of a woman's tongue for a malignant growth.

"A country doctor, you see, sometimes gets a piece of surgery, but the hospital men in Salt Lake make a great roar if the men in the country do more than open a few boils."

The following letters explain themselves. They are samples from many. We try to keep the correct address of every Alumnus, but we are not omniscient. With the aid of Polk's directory we have just succeeded in locating over one hundred Alumni who had moved and who had not sent in their new addresses. There are no doubt a considerable number whom we are not able to find, even with the aid of the directory, who are still practicing in some part of this country.

What we need is more letters like the one by Dr. Woodyard published in this issue.

DENVER, COL., Aug. 5, 1900.

WM. J. TODD, Baltimore, Md.

Dear Doctor.—I received the enclosed bill which I return you, thinking some mistake has been made. It is true I subscribed for the ALUMNI JOURNAL but it is also true that I have only received 4 or 5 copies during the past year. So of course, I do not intend to pay for what I do not get.

Another thing that has made me feel rather unkindly toward the Alumni or rather the College management is that they do not even take the trouble to send me an annual copy of the College catalogue so that I may at least know something about the College from which I graduated and keep somewhat in touch with it.

Yours truly,

BALTIMORE, MD.

DR. ———.

My Dear Doctor.—I am in receipt of your favor of the 5th instant. Our journal is a quarterly, issued on the first day of the months of January, April, July and October. If I have read your letter correctly you have received all the numbers published this past year.

As to your charge against the College management—let me give you information you do not seem to possess. When the graduate leaves the College he seldom thinks of writing to the secretary of the faculty, giving the new address where he has taken up his life's work, he takes it for granted his movements are known to all the members of the College faculty.

When the "staff" started this JOURNAL they made use of the list which the College faculty had of the graduates. Much to their sur-

prise many copies of the JOURNAL were returned marked by the postmaster—"dead," "moved," "not known," etc. After two years of work and much expense the management has succeeded in getting the list very near correct. Yet each new quarter brings the report that some have died in the past three months, some removed and left no address. Doctor, did you send your address to the secretary of the faculty when you removed to your present location?

Please reconsider your decision as expressed in your letter, give us your financial and moral support. We need subscribers to comply with the postoffice laws, to register our JOURNAL and secure the lesser rate of postage. Pardon me if I say your dollar is a very small outlay to set opposite the time and labor of the members of the editorial staff in their endeavors to bring into closer relations the Alumni who are scattered widely over the world.

Fraternally yours,

WILLIAM J. TODD, Business Manager.

The "Staff" of this JOURNAL is making an effort to complete a file of the catalogues of the College of Physicians and Surgeons of Baltimore, Maryland. If you have a copy of a catalogue dated earlier than the year 1890 please forward to the following address and credit will be given for the kindness.

Yours fraternally, WILLIAM J. TODD,

Postal Station No. 202, Baltimore, Md.

Dear Doctor and Fellow Alumnus:—We solicit your aid in making a collection of the writings of the late Dr. George H. Rohé. If you have any reprints of his articles and are willing to send them to the subscriber to be bound in book form with others we have, we will appreciate your assistance and give the proper credit. Please give the titles of the reprints you have and your address on a postal card, directed as below and we will send the necessary stamps if we do not possess a copy of the reprint named. You will greatly oblige, and assist in putting in permanent shape the writings of this gifted man and beloved teacher.

Fraternally yours, WILLIAM J. TODD,

Baltimore, Md.

Postal Station No. 202,

WIEN, July 10, 1900.

Dear Doctor Friedenwald.—Thus far our trip has been immensely successful. Before settling down here we “did” the German cities, visited the hospitals, art galleries, opera houses, investigated the water works (incidentally the beer works also) and got a pretty good idea of the internal arrangements of the cities.

What struck me particularly was the extraordinary care with which the water works of Bremen and Hamburg were conducted. They have the filtration system and since its introduction typhoid fever has almost disappeared. In connection with this I may say that previous to visiting the system we inquired from every native whom we met as to the wholesomeness of the drinking water. They seemed astonished at the query—“Oh, it must be good” they say, “the *animals* which drink it appear healthy.” But they are truly far ahead of us in the general sanitary conditions of the cities. Notably so is Hamburg, which has made giant strides since the cholera epidemic. We were very fortunate in having letters of introduction to the Hamburg-American Steamship Co. Their “*oberst arzt*” spent a day with us, showing us the hospitals, disinfection plants, etc.

We have been in Vienna since the early part of May and I find the work in skin particularly good. There is an enormous amount of material and it is well used. Fortunately many of the skin eruptions which one sees here are almost unknown on our side, or are at least rare. Filth and extreme poverty combined with vitiated constitutions appear to be prime factors. The simplest cases are taken in the hospital, as they claim it is useless to attempt measures for relief unless the patient is removed from his ordinary environments. The amount of syphilitic disease is prodigious. It is computed that 13% of the inhabitants have the disease in one of its numerous forms, and from what I have seen of it, I don't doubt the statistics. The syphilitic ward (Neuman's) contains 120 beds and there is never a vacancy. Lang's ward contains about 75 beds and the few times I have been there it was filled. Besides this the outdoor or ambulatorium treats on an average 40 cases a day.

The genito-urinary work is not good. It is conducted in a careless, slipshod sort of a way and the individual case never treated. Per-

sonally, I have done better work in this branch than they do here. Prof. Finger who has charge of the work has been away for a long time and it is probably due to his absence that the work has deteriorated.

Altogether the Viennese are about as lazy a lot of people as you are liable to find in a civilized country. Every week has some Saint's Day or somebody's birthday, or some other cause for celebration. And they are never content with the one day but always throw in an extra one for recuperation. Saturday is always a half-holiday for the assistants and a full holiday for the professors. And the way they cut down the semester would make a medical student green with envy in America. Instead of beginning the first of April and ending the last of July, they begin the last of April and end the first of July, and then have the nerve to call it a 4 months' course. Had it not been for my persistence in visiting the wards and ambulatoriums there was not enough organized work to have kept me busy 3 hours a day. I put in 6 weeks of hard work on histology and pathology of the skin, an entirely new branch here and was well repaid. It was given by Dr. Lowenbach, the best skin pathologist in Vienna and as it was the first time a course had been given on the subject he was enthusiastic. There were but 5 in the course and it was therefore in the nature of individual instruction.

We leave here the latter part of July for Paris to be in time for the medical congress, after which we will likely "do" the Netherlands until September when we will settle down for the Berlin part of the program.

Believe me to be sincerely,

MELVIN ROSENTHAL.

DR. WM. S. GARDNER, Balto., Md.

Dear Dr. Gardner.—THE ALUMNI JOURNAL never receives a more cordial welcome than when it reaches my desk and I have learned to look forward to its coming. It certainly deserves success and prosperity and should receive the support of every live Alumnus. Indeed it bears more ear marks of success than any other journal of like character I have seen.

As chairman of the Alumni of this State I fear I have been somewhat negligent in making reports. Some months ago—I am ashamed to say how many—I sent out a letter to each of the fourteen men in this State and received responses from most of them which I enclose herewith. I also enclose a reprint from Dr. J. W. Pickel, '84, of Crystal City, Mo. He is chief surgeon for the Pittsburgh Glass Co.'s works at Piedmont, Mo.

J. H. Holmes, I think of the class of '83, while not engaged in active practice keeps well in touch with the profession's progress. He is proprietor and editor of *The Banner* at Piedmont, Mo. At present he is rendering the State valuable services as trustee of its blind asylum.

Geo. M. Phillips, '89, Joseph Meade White, '96, and myself, '95, all represent the P. & S. in St. Louis. Phillips is a specialist in G. U. work. White is doing general work, and I am confining myself to surgery and gynecology.

Some weeks ago I ran across Dr. W. M. Eggleston of the class of '74. Please send him a copy of the *JOURNAL* and you will no doubt get another subscriber. His address is 6045 Horton Place, St. Louis. He recently settled here but has already acquired a busy practice in the western suburbs.

E. M. Hetherington, '88, is located at Kansas City. J. E. Sawtell, '86, is another representative at the same place and is doing nose and throat work.

A. S. Hawkins, '79, is located at Monett, Mo.; L. R. Leith, '93, Exeter, Mo.; W. C. Carter, Lebanon, Mo.; P. H. Stultz, Bear Creek, Mo.; George N. Quinn, Holcomb, Mo.

Every once in a while I am agreeably surprised to have one of the boys walk into my office and introduce himself. I am always delighted to see any P. & S. man of whatever year's class, and feel much buoyed up after a talk about people and places that are familiar as having been associated with our school years. W. A. Wickline, '95, spent a day with me on his way east. J. H. Colson, '93, also dropped in one day for an hour between trains. He is located at Waldo, Florida. I have had a like pleasure from Boucher, '94, and Wyche,

'93, who is now in the army and stationed here. I hear that the P. & S. faculty are expansionists of the purest type as evidenced in the improvements at the College. I look forward with much pleasure to visiting Baltimore in the early fall and am anxious to see my old friends and haunts.

Success to the P. & S., the Alumni Association and its JOURNAL.

Sincerely,

JOHN C. MORFIT, '95.

GREENEVILLE, TENN.

DR. WM. J. TODD, Baltimore, Md.

My Dear Doctor.—I enclose you herewith one dollar for the ALUMNI JOURNAL. I was re-elected, Jan. 1st of the present year, physician to the Jail and Poor Asylum for a term of four years at an increased salary. I am glad to report that I am enjoying a nice practice. I want to spend about two months in Baltimore doing post-graduate work in general medicine and diseases of children.

I send you a list of the Alumni that I know of in East Tennessee.

A. C. Emmert, '75, Bluff City, Tenn.; D. M. Miller, '87, Indian Springs, Tenn.; J. D. Masengill, '74, Blountville, Tenn.; J. W. Cox, '84, Johnson City, Tenn.; Dr. Cox was Asst. Surg. in the 6th Immunes and saw service in Porto Rico. Dr. Patton, '89, Telford's, Tenn.

Dr. F. G. Anderson, '89, is enjoying a lucrative practice at Wabash, Va. Dr. I. E. Huff, '92, is located at Simpson's, Va., and is very popular. Dr. Jas. H. Bogle, '93, has an extensive practice at Rocky Gap, Va. Dr. D. H. Thornton, '93, and Dr. Sam Holroyd, '90, are succeeding nicely at Athens, W. Va.

I would be glad if the members of the class of '91 would send me a short sketch of themselves and I will write a short history of the class for publication in the October number of the JOURNAL.

Yours fraternally,

S. WALTER WOODYARD, '91.

We hope the class of '91 will respond promptly to Dr. Woodyard's request.—Ed.

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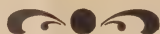
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Personal Notes.

DR. E. M. VARNEY, '95, died suddenly at White Mills, Pa., September 7, 1900.

DR. A. C. EMMERT, '75, died at his home, Bluff City, Tenn., in the summer of 1900.

A CARD.

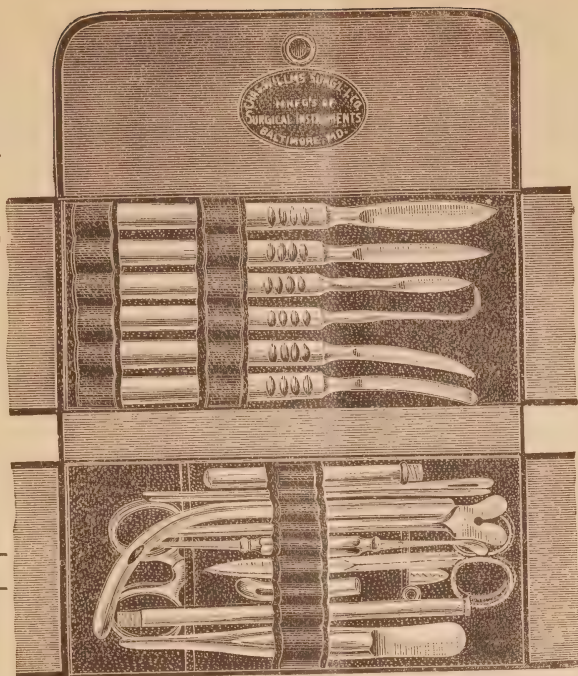
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INTRODUCTORY ADDRESS, COLLEGE OF PHYSICIANS
AND SURGEONS, BALTIMORE, SESSION OF 1900-1901.

BY DR. EDWARD N. BRUSH, PROFESSOR OF PSYCHIATRY.

(Concluded from No. 3.)

You may ask, gentlemen, what of the special department of medicine which it is my pleasure and honor to teach. I remember that the gentleman who last year addressed you on this occasion magnified in a very proper and modest way his own department, and I may be excused for following so excellent an example. Psychiatry or the science and treatment of diseases affecting the mind is a department in the curriculum of this college which will, I hope, appeal to you, and I can with all honesty and sincerity assure you that no department of medical science possesses greater interest or offers a broader field for original investigation and discovery.

The student in this field must bring to his aid, if success is to be attained, a knowledge of the anatomy and physiology of the nervous system, of neurology and neuropathology. He must be a student of psychology and of sociology. He must be not only a student of books but of men and women, and of children above all.

It will be taught you in your studies of physical diagnosis that you cannot successfully investigate abnormal chest sounds if you know

nothing of the sounds to be heard from a normal thorax. So of the study of aberrant mental action. How many of you have watched and studied and analyzed your own mental operations. How many of you have observed, as far as it is possible to observe, what the mental processes of your friends and companions are? How they arrive at conclusions, what things sway or decide their judgments, what appeal to their emotions and what influence their wills.

You say of this one, he has a quick intuition, of another, he is stubborn and hard to convince, of another, he is feeble of purpose and vacillating. Have you ever asked why, have you ever stopped to inquire whether he who apparently comes to an intuitive conclusion, has not back of that a mass of experiences and of collected facts, from which he is able by comparison with the case in point to arrive quickly at a conclusion which is inductive really while it seems to be intuitive. Have you ever watched the mental development of a growing, healthy child? How from the lower to the higher its mental operations are gradually built up, experience added to experience until judgments commence to be formed, and how its memories based first solely upon the most simple sense impressions, become more and more complex, and so on through its various steps from infancy to childhood and thence to youth. If you have not done this, improve the first opportunity you have, it will be more valuable if carefully and systematically undertaken than any text-book upon psychology I can recommend.

You must be close students and good judges of men and women and careful observers of all things which modify their thoughts and actions.

I need not tell you that I trust that in order to apprehend the problems connected with insanity and its treatment you must, above all, be grounded in the principles of general medicine and medical diagnosis. In other words you must be general practitioners before you can be specialists, in this, or indeed in any other department of medicine. I know of no branch so-called, of medical science which does not find in the care of the insane some opportunity of displaying its usefulness.

I have said that some knowledge of sociology is required in dealing with problems of insanity. When you remember that of all conditions which interfere with the daily life and occupation of mankind, none so thoroughly incapacitates its victims as insanity, that special means of care, special nursing and in the majority of instances removal from home, and confinement against the patient's will, are necessary, you will at once admit the truth of my statement. These things involve the enactment of laws regulating and controlling confinement and treatment of the insane, the appropriation of public money for the care of the dependent insane, who in the words of Daniel Defoe constitute "a rent charge upon the whole community," and this rent charge must be collected by public taxation.

Remember that in addition to this the departments of public jurisprudence have constantly to deal with certain intricate problems incident to the plea of insanity as a bar either to trial or as a defense.

Then, too, in the disposition of property by will, deed of trust, or other conveyance, the question is always present, though happily not always of necessity raised, is or was the person conveying this property or making this trust of "sound and disposing mind and memory."

The whole community and its laws therefore must take into account this great subject, and its public expenditure is regulated in a measure by it. The integral parts of the body politic, the families, are just as thoroughly under its dominating influence; questions of marriage, the continuation of family relations, the descent of property, all are modified in more instances than is generally known by this one word "insanity."

The fate of dynasties and nations has been controlled by it, and pages of history stand to-day which would read very differently had not insanity placed its finger upon some ruler or his minister and changed everything.

What effect, for instance, had the insanity of Chatham in preventing the conciliation of the American Colonies whose friend he was? What more serious effect, the commencing madness of George III, destined to end his days in hopeless fatuity, blind and demented?

I think, however, I have sufficiently magnified my subject without showing further how insanity has had to do with literature, art and science, as well as with law and politics.

You will, I am sure, prefer that I shall point out to you some lines which you may follow in this department of medical study and practice which shall offer some hope of your adding something to our knowledge of the subject, or which shall afford you an opportunity of being of use to your fellowmen. In its purely scientific aspects psychiatry affords a field to the thoroughly equipped student which is, I believe, unsurpassed to-day in any department of medicine.

Of the etiology or pathology of many forms of insanity we are to-day either in grave doubt or totally ignorant. Between the symptoms observed during life and the lesions found after death in the brain of one dying insane, we are at present utterly unable to make any certain and definite connection.

Clinical psychiatry is a study which, pursued in the wards and laboratories of a well-equipped hospital, offers a most inviting field.

Whether insanity is increasing out of proportion to the growth of population is a moot question. I am inclined to think that it is. Much of the apparent increase is due to three, at least, distinct causes: First, the average duration of life of the insane owing to better care, better hospitals, larger liberty, more out-of-door life has increased in the last half century some two or three years, so that there is an increase by reason of accumulation of those who do not recover but who live longer. Second, increasing knowledge of the subject and more accurate diagnostic ability have brought about the recognition of more cases of insanity than formerly, and third, better hospitals and greater confidence in hospital care for the insane have resulted in many cases being known which would formerly have been concealed at home.

I have spoken of the importance of preventive medicine and the vast amount of work yet to be done in that field. In psychiatry it has abundant scope. From whatever period man has occupied the earth, from that period insanity has no doubt existed. We are compelled to this conclusion from our belief that from the beginning of

history the brain has been subject to the same laws which we must admit have governed the other organs of the body: development, disease, decay. We must conclude then that its development has been liable as now to arrest and consequent imbecility or idiocy, that disease has from the beginning interfered with its normal physiological activities; and that decay, senility, came to the primitive man as to the man of Shakespear's time and left him, "in second childishness and mere oblivion; sans teeth, sans eyes, sans taste, sans everything."

Whatever increase of insanity out of proportion to the increase in population of the globe there may have been is one of the penalties of civilization, and in a measure one of the penalties which we pay for the intellectual superiority which modern man has over his ancestor who dwelt in caves and clothed himself with the skins of animals slain with his rude stone implements.

The stability of the brain depends upon inheritance and education. The forces or the stress which tend to interfere with its stability have an intimate relationship with the health of the individual, his environment and occupation.

If this is true you can readily perceive how important it is that a wise medical opinion should guide marriage, education, environment, and occupation, and how much can be done for those who unfortunately inherit a defective nervous system by a proper direction of their lives. Heredity, certainly in those who live, you cannot control, and for the generations yet unborn the task is, in the light of present experience, about as impossible. Some improper marriages, you may, by wise counsel, prevent, but in the majority of instances, even when your advice is sought, unless it meets the views of those who seek it, Cupid will prove more powerful than Esculapius.

In education we have an element in the cause or prevention of insanity. I use the words cause or prevention advisedly which deserves far more attention than it receives.

Goethe well says in *Wilhelm Meister's Apprenticeship*: "Nothing more disposes us to madness than affecting singularity, and nothing assists more to preserve our common sense than a life spent in the ordinary manner, amidst general society." "But in truth" he con-

tinues "there are many things in our system of education and in our civic institutions, to predispose us and our children to mental derangement."

What was written a hundred years ago is certainly applicable to to-day, there are undoubtedly many things in our system, if system it may be called, of education which predispose to insanity and likewise many things in our civic institutions.

In altogether too many instances the education of the young is carried on in the most reckless and haphazard manner. In too many cases the system so-called is like an attempt to crowd a mass of material into a given space without any attempt to ascertain its size or capacity, or its ability to retain the material.

In the schools of Baltimore alone, there are hundreds of children who should be in special schools under special training for defective children. And yet term after term, year after year, the fruitless experiment is tried of making the brains of all school children conform to a fixed and arbitrary standard.

Some of these children are susceptible of only the most elementary training, some should be subject to no attempt at education at all beyond manual training. All should be examined at frequent intervals by physicians skilled in neurology and psychiatry. Their teachers should be selected with the greatest care. It is from this class that the adult degenerates so-called are drawn, and it is the duty of the community to see that their degeneration is not increased by ill-directed efforts at an education, for which they are not capable and intent or value of which they cannot appreciate.

Montaigne says: "I willingly fall again into the discourse of the vanity of our education; the end of which is not to render us good and wise, but learned; and she has obtained it. She has not taught us to embrace virtue and prudence, but has imprinted in us their derivation and etymology. We know not how to love it, if we do not know what prudence is really and in effect and by experience, we have it, however, by heart."

If we have in faulty education one of the elements which tend to mental unsoundness how much more do we have in the lives which

we lead. The straining after the meretricious in everything, the desire to be "seen and known of men" which seems to be the predominating social force of this end of the century, brings as the inevitable result of the rush and push, the disappointment and ruin which follows upon so many misguided ambitions, its train of physical and mental wrecks. Among all classes there is in this age and country a wonderful striving for all the objects of wealth, honor and power. We need to think only upon the strife of politics, the hazards of commercial gambling, and the wear and tear of hard professional toil to see how many there must be who from their daily experiences have derived, both to their minds and bodies new feelings and impulses and new susceptibilities of disease. These susceptibilities belong chiefly to the brain and nervous system and they are apt to come into frightful activity when least anticipated by the victim.

A writer in the *Spectator* says: The man indeed who goes into the world only with the narrow views of self-interest, who catches at the applause of an idle multitude, as he can find no solid contentment at the end of his journey, so he deserves to meet with disappointment on his way; but he who is actuated by a nobler principle, whose mind is so far enlarged as to take in the prospect of his country's good, who is enamored with that prize which is one of the fair attendants of virtue, and values not those acclamations which are not seconded by the impartial testimony of his own mind; who repines not at the low station which Providence has at present allotted him, but yet would willingly advance himself by justifiable means to a more rising and advantageous ground; such a man is warmed with a generous emulation." And the writer might have added such a man has that within him which is one of the best safeguards against mental wreck.

In view of what preventive medicine has done in checking the progress of other maladies may we not hope that something may be accomplished in staying the onward march of insanity. If the nineteenth century leaves us no other legacy of work unaccomplished surely here is a labor worthy our utmost pains.

Gentlemen, I have detained you long enough. I have endeavored to awaken or encourage in you an optimistic feeling as far as con-

cerns the opportunities before you of doing good work, of adding something to the sum of human knowledge, something to human weal.

I would not only do that but I would encourage in you a belief that you are equal to the task; that in some degree you will pay your debt to the world, for I would not place before you tasks to be accomplished, difficulties to be surmounted, honors to be won without encouraging in you self-reliance.

And now I think I can do no better in conclusion than to quote from the address of Pasteur, at the opening of the laboratory named in honor of him in Paris, some words which really sum up all that I have said to you. "Young people, confine yourselves to those methods, sure and powerful, of which we as yet know only the first secrets. And, all, whatever may be your career, never permit yourselves to be overcome by skepticism, both outwardly and barren; neither permit the hours of sadness which pass over a nation to discourage you. Live in the serene peace of your laboratories and your libraries. First ask yourselves, 'what have I done for my education?' then, as you advance in life, 'what have I done for my country?' so that some day that supreme happiness may come to you, the consciousness of having contributed in some measure to the progress and welfare of humanity."

A GREAT DANISH DOCTOR. ADDRESS DELIVERED BEFORE THE MEDICAL SOCIETY OF THE COLLEGE OF PHYSICIANS AND SURGEONS, JANUARY 30, 1901.

By DR. FRANK DYER SANGER, '88.

When one considers how few of the things which constantly assail our senses are appreciated in anything like their due proportion, how few excite in us even a passing curiosity regarding their causation or the relation which they bear to other things about us, how few, indeed, make any impression upon our consciousness, we are astounded.

This is particularly true in the domain of Clinical Medicine. We

go groping about, our senses obtunded by the self-satisfying delusion that we are as acute (if not more so) as our neighbor, till some one nudges us and points out something new, immediately beneath our noses, possibly within our noses, and we wonder, not a little, why some one did not discover it before, still more why we did not.

It has ever been so, it will doubtless so remain.

The man who raises his perceptive faculties but a millimeter above the common level, may make a lasting name for himself, but to few is granted the privilege of giving to the world, at the same time observations so far reaching in their beneficence as those of the late Dr. Hans Wilhelm Meyer, because in few men are accurate observation, close thought, and broad scientific knowledge, so perfectly blended.

Men had been observing cases of deafness since the world began I presume, many had noted the peculiar "dead" pronunciation of individuals who were unable to breathe through their noses, it is quite probable that it had been observed that individuals who breathed through their mouths were apt to be deaf, but no one seemed to have gotten much further till Meyer began to ponder these things.

Meyer noted that transitory interference with pronunciation occurred in individuals whose noses were temporarily obstructed, in which case the tip of the nose was apt to be red and swollen, while in persons whose pronunciation was habitually "dead" the tip of the nose became sharpened, its lumen narrowed, the alae thinned from atrophy of the unused muscles. He cleared the nostrils of a young woman from Jutland, who came to him in the autumn of 1867, and removed her faucial tonsils, reducing the swelling of her soft palate, and, having failed by a system of training, to educate her out of her false pronunciation, came to the conclusion that there must be some obstruction in the area between the nose and throat. Finding rhinoscopy impracticable, he introduced his finger into her nasopharynx, and by so doing created an epoch in Laryngology and Otology, for he found, much to his astonishment he states, that the cavity was almost entirely filled with soft yielding masses, feeling very much like a bunch of earth worms, and hanging down from the

roof of the pharynx, completely closing the posterior nares. These he removed, and was rewarded by the restoration of free nasal breathing and perfect pronunciation to his patient. He immediately began to practice the same procedure with his cases of deafness in whom the naso-pharynx was obstructed, and found that in a large number of patients hearing was perfectly restored.

He was entirely in the dark regarding the nature of the growth. "The growths were at that time quite new to me" he says; he was not able to find any description of them in the ancient or modern works on surgery or morbid anatomy which he consulted. He therefore set to work to find out all about them himself. This fact, it seems to me, attests the genius of the man more than the simple discovery. His work was so exact, so thorough, so comprehensive, that in the thirty some years which have followed, it has been subject to but slight revision, and practically nothing has been added to it, though tomes have been written upon the subject. In this respect Myer's discovery and work, is almost unique when compared with that of other path-finders in medicine.

It is true that Meyer was not the first to find growths in the naso-pharynx. Czermac in 1860 found that while trying to use the Eustachian Catheter in certain instances the beak of the instrument met with resistance in the naso-pharynx, and he was able to see the growth. His observation was shortly afterward confirmed by Turck and Semeleder. Voltalini of Breslau had also mentioned the growths and assayed to remove them in course of treatment for deafness, and Lowenburg, of Paris, had described cases under the title of Pharyngitis Granulosa.

Sir Andrew Clark, of London, also published an article in the London Hospital Report, 1 Volume, in 1864, on Naso Palatine Gland Disease.

Meyer's work, however, was so much more complete, that with but little dissension, he has been accorded full honor for having contributed to the world a discovery that will benefit the race as long as man exists.

A great deal of interest attaches, therefore, to the personality of

this man. As I said before, Dr. Meyer was evidently an observant man, a thinker, and a man of broad scientific attainments. He was a physician in the broader, truer sense, an altruist, a man devoted to humanitarian ends, rather than to the satisfaction of scientific curiosity or the sustenance of therapeutic dogma. A man not given to personal aggrandizement, modest, true of heart, self-sacrificing to a degree, beloved of his patients.

HANS WILHELM MEYER was born in the year 1824, in the Danish town of Frederica, where his father, a surgeon in the Danish Army, then lived. From 1826 to 1843 he was educated at Gluckstadt in Holstein his father being transferred here with his regiment; from 1843 to 1847 he studied medicine in the University at Copenhagen, finishing his studies in 1847, passing his final States examination with unusual credit, and for a time assisted his father. In 1851 he went abroad, studying pathology and therapeutics in the universities and hospitals at Würzburg, Prague, Vienna, Montpellier, Paris, London and Edinburgh; returning to Copenhagen and settling as a practitioner in 1853. Although he became quickly involved in a large and imperative general practice, he found time to devote to special work in Laryngology and Otology, in which field he occupied a most distinguished position up to the time of his death.

"When Meyer passed his finger 'behind the veil'" says a writer in the "Practitioner" "he gained for himself a place among the Immortals." "If he did not strike a new continent of disease, he discovered a rock, not previously marked on any nosological chart, from which the human ship was likely to suffer grievous damage."

It is not necessary at this time, and before this audience to dwell upon the beneficence of Dr. Meyer's work.

When you stop to think that the chief function of a child is to grow, and that anything that interferes with growth not only influences the entire life history of the child, but makes its impress upon the child's posterity; when you recall how difficult respiration stunts the child physically and mentally, how appetite, digestion, sleep and the reflexes may be influenced, how the physiognomy may be changed, and to what extent the hearing is menaced, and remember

that by a comparatively simple surgical procedure the whole thing can be corrected as by the wave of a magic wand, you begin to realize the magnitude of the benefaction.

Dr. Meyer published the first account of Adenoid Vegetation in the Danish Hospital Tidende in 1868. In 1869 Schmidts Jahrbucher gave a report of the work, and in 1870 Meyer published his more extended investigation in the Medical and Chirurgical Transactions of London (see Volume LIII). Later in 1873 a still more exhaustive and complete description of the etiology, morbid anatomy, symptomatology, sequelae and treatment of adenoids appeared in the Archiv fur Ohrenheilkunde.

Strange to say the Medical World, even the Specialistic World, took hold of the work very slowly. Eleven years after his first publication of his researches in English, Meyer presented the subject in London in 1881 to the International Medical Congress, and it was then new to many men who had devoted their lives to nose, throat and ear work.

Shortly before his death he published the first paper of what would have been a more extended work on Adenoid Vegetations.

The paper on the Universality and Antiquity of Adenoid Vegetation contains some very interesting research work, an abstract of which appeared in "The Practitioner," July, 1896.

Of his publications upon other subjects, I need not speak. All his literary work was done with elaborate care. It is said that an article in Schwartz's Handbuch der Ohrenheilkunde on the history of Otology took him a year and a half to write, though it is only a few pages in length.

Dr. Meyer read extensively and went far afield. He was interested in philosophy, music, literature, natural science, religion, in fact everything which attracts a man of broad culture. He was an enthusiastic astronomer, and spent many nights with his telescope.

In 1880 Dr. Meyer received the Swedish order of Nordstjernen as an acknowledgment of his treatment of the son of the King of Sweden. In 1884 he was made Honorary Doctor of the University of Halle Ehrendoktor. In 1884 the Danish title of Etatsraad

was conferred upon him. He was honorary member of several foreign societies, among others the American Laryngological Association and the London Laryngology Society. During the spring of 1895 Dr. Meyer suffered from influenza, which weakened him so much that he went away to Italy to rest, reaching Venice on his way homeward he again became ill with typhoid fever the Italian doctors said, and died on the third of June, in his seventy-first year.

The best judgment of a man is formed by his compeers. The world measures merit by curious standards. Visit that great National Valhalla Westminster Abbey, and you will find that the most prominent places have been allotted to men whose chief occupation was the *destruction* of human life.

Within the past few months a man has been knighted because he invented a gun that would kill more people in the same space of time than was ever accomplished before. Few, indeed, are the monuments erected in honor of the medical profession, and yet, to quote from a recent writing of Dr. Osler, "Measure as we may the progress of the world materially in the advantages of steam, electricity and other mechanical appliances; sociologically in the great improvement in the conditions of life; intellectually, in the diffusion of education; morally, in a possibly higher standard of ethics there is no one measure which can compare with the decrease of physical suffering in man, woman and child, when stricken by disease or accident."

The privilege of diminishing physical suffering is the true physician's chief emolument.

It is gratifying, however, to note that the proposition made immediately after Meyer's death to erect a statue to him in Copenhagen, met with the most sympathetic reception all over the civilized world. Physicians, surgeons, specialists, general practitioners and grateful patients, contributed to its erection, and to-day it stands in one of the beautiful squares in East Copenhagen a fitting memorial to a great benefactor of the human race. The monument was completed in August, 1898. It was erected in Gefion Square, and consists of a bust, more than life-size, of the great Danish Doctor on a Hermes pedestal of red granite, which rests in turn upon a base of rough gray

granite, consisting of a number of steps leading up to the monument. The bust is by the Finnish sculptor and friend of Dr. Meyer, Runeburg. Upon the steps leading up to the monument stands the Goddess Hygeia, by Prof. Bisson, resting her left hand upon the staff of Aesculapius, while in her right she holds up the Palm of Honor to the great physician. The bust faces appropriately the institution for the deaf and dumb. On the front is inscribed, Laegen (Dr.) Hans Wilhelm Meyer, B. 25 "Oct. 1824," D. "3 June 1895." On the back, "This monument was erected in the year 1898 from contributions from Denmark and abroad, below are the contributing countries:

Australia, Austria, Batavia, Belgia, Britania, Civitates, Trederatae, Americae, Septentrionales, Dania, Gallia, Germania, Helvetia, Hesperia, Hungaria, Italia, Norvegia, Polonia, Russia.

Sir Felix Simon, originator of the movement to erect the monument, delivered the address upon the occasion of its unveiling and presentation to the City of Copenhagen.

It is interesting to note that upon the day of the ceremony in the autumn of 1898, Dr. Holger Mygind showed Sir Felix the patient in whom Dr. Meyer had first discovered Adenoids thirty-one years before.

The world owes much to the little Kingdom of Denmark. She has given us the noble history of a brave people. We are all indebted to her for her beloved son Bertel Torwaldsen, whose works are perhaps second only to his great master Canova. Denmark has given us the hero of the greatest tragedy ever penned. Our little sisters and brothers are perhaps *more* deeply indebted to her. Think of the thousands of children who having been drowsed by the fairy witchery of the Wonder Tales of Hans Christian Andersen, are enabled, through the beneficence of the work of Hans Wilhelm Meyer, to lie down and sleep that calm, refreshing sleep full of sweet dreams that comes from quiet breathing.

A NEW METHOD OF TREATING THE ORBITAL CAVITY
AFTER EXENTERATION WITH THIERSCH GRAFTS.

BY DR. HARRY FRIEDENWALD, '86.

PRELIMINARY NOTE.

John K., aged 72 years, farmer, was admitted to the Baltimore City Hospital on October 2nd, 1900, with destruction of the lower lid of the left eye, together with the inner and outer portion of the upper lid; the conjunctiva bulbi was lost and the eyeball exposed on both sides and below. The eyeball was of normal size but the cornea replaced by a dense white tissue, similar to exposed sclerotica. The ulceration and the infiltration extended somewhat over the malar region. The diagnosis * was epithelioma and removal of the entire contents of the orbit with the diseased lids and neighboring skin was recommended.

On October 7th the eye and the neighboring region as well as the left thigh were thoroughly cleansed and as far as possible sterilized and bichloride of mercury dressing applied as a preparation for the operation.

Operation.—October 8th: Under ether anesthesia incisions were made through the upper portion of the upper eyelid and the base of the lower lid following the line of the margin of the orbit, which met on the side of the nose and beyond the affected region over the malar bone. The incision was at all points sufficiently distant from the diseased tissue and was carried down through the periosteum to the bone. The periosteum was next separated with a small raspatory from the underlying bone as far into the orbit as it was possible to reach. The entire mass was then severed near the apex of the orbit with scissors. The hemorrhage having been easily controlled by a pressure, the cavity was thoroughly cleansed of remaining portions of tissue (especially near the apex).

In order to diminish the size of the very large wound the skin over the temple and malar bone was loosened from the underlying tissues. It yielded sufficiently to be brought together by sutures to the extent of about one inch.

* Subsequently confirmed by microscopic examination.

Long Thiersch grafts were next obtained from the thigh (which had been prepared for the purpose) and cut into pieces sufficiently long that when applied to the orbit they reached from the apex to the margin. They were carefully spread out upon the bone surface and firmly applied and no part of the wound was left uncovered. Small pledgets of gauze soaked in sterilized saline solution were next carefully applied throughout the entire cavity and the center filled with dry gauze under a slight pressure so as to prevent hemorrhage. A sterile dressing was next placed over the entire orbit and the wound of the thigh dressed.

The patient recovered without any untoward symptoms and his temperature remained normal.

Dressings were renewed weekly and it was gratifying to observe that all the grafts adhered and that the wound which usually requires a long period for complete healing was entirely well in a few weeks.

On November 20th the patient was presented cured at the meeting of the Medical and Chirurgical Faculty and a few days later returned to his home in West Virginia.

TRANSMISSION OF MALARIA BY THE MOSQUITO.

By H. R. McGRAW and C. H. BRUECKNER, '01.

The theory that mosquitoes and other insects bear a relation to the transmission of disease, especially of malaria, appears to have been maintained nearly two thousand years ago, by the Roman writers, Varro, Vitruvius, and Columella; and was hypothetically referred to in this country, by Crawford of Baltimore, in an article which appeared in the *Baltimore American* as early as 1807. Nott, of New Orleans, made reference to it as a fact already known; King, of Washington, renewed the hypothesis in an elaborate article in 1883. Prior to this time as the organism of malaria was unknown (first announcement of its discovery was made in 1880 by Laveran, a French army surgeon, who called it *hæmatozoon malarie*), it was difficult for these observers to prove the theory, Laveran in 1884; Flügge in 1891; Pfeifer in 1892; and Manson in 1894 being some

of the more recent writers to advocate this theory. The inhabitants of certain malarious regions in widely separated parts of the world also believed that the mosquito was the cause of malaria.

Among the first experiments, or perhaps the first experiment, made to test this theory, appears that of Bignami and Dionisi in Rome in 1894, with negative results. Following these experiments a great scientific interest was manifested, particularly among the English and Italian observers, and called forth much experimental and original research work. Two theories as to the mode of infection were maintained. Manson in 1894, and subsequently in his Goulstonian lectures in 1896, pointed out certain resemblance between the etiology of malaria and Filariasis, and completed the analogy by advancing the theory, that as the mosquito removed from the human body *filaria nocturna* and in turn acted as host to the parasite, so also the mosquito might remove the plasmodium of malaria from man and serve as its host harboring the parasite in its body until fully developed and reproduced and then spreading it abroad in water and dust to reinfect man; he did not believe that man was directly inoculated by the stick of the mosquito. In a later article Manson somewhat changed his views, and stated that the mosquito in abstracting blood injects the parasite and he also went so far as to say that each form of malaria requires a special kind of mosquito. Ross' experiment in 1894, of allowing the mosquito to feed on blood of malarial patients containing crescent bodies, subsequently examining the stomach of the mosquito and finding the plasmodium developed into spheres and flagellated forms, seems to support Manson's theory of 1894 that the mosquito removes from man the malarial parasite, but does not give evidence of the spread of the disease, as will be seen later by the experiments of observers under the direction of Manson; his later statement of direct inoculation will be supported. Bignami, in 1896, advanced the theory that malaria was caused by direct inoculation by the bite of the mosquito; he compared the process of infection to the one already known for the production of Texas fever of cattle by the bite of the tick *Pyrosoma bigeminum*. Bignami in August, 1898, began inoculation experi-

ments on healthy men with mosquitoes from malarial districts, and in two cases failed to infect his human subjects. A possible explanation of his failure he found in the assumption that the mosquitoes were of a species not suitable to act as host for the parasite. An important article by Grassi mentions districts where mosquitoes are abundant and no malaria exists; explaining the absence of malaria by the fact that certain species of the mosquito is absent, while in other districts where the certain species of mosquito is found, malaria is rife. Ross in a report in June, 1900, makes mention of his experience while on a long cruise, touching at points where mosquitoes were abundant and very annoying, no cases of malaria being reported; he does not state the variety of mosquitoes encountered. These last observations demonstrate fairly well that only a certain species of mosquitoes acts as host for the parasite.

The *Anopheles* appears to be most frequently associated with cause of malaria, and the article by Dr. Thin only describes the *Anopheles* and their different characteristics when taken from widely separated malarious districts. The body of *Anopheles claviger* is of medium size, head is well defined from body by a slender neck. Thorax and abdomen ash brown or black in shade, the segments of the abdomen well defined, especially towards the tail. Legs are long and slender, and light brown in color. Proboscis of good length and dark brown in color.

The life history of the parasite after removal from man by the mosquito has been fully studied by Celli, Grassi and others; the parasite removed from man is taken into the stomach wall of the mosquito where it develops and appears as sporozoids, they then pass through the body cavity of the mosquito and are next found in the salivary glands, passing from there through proboscis to the skin of man in the act of biting.

Ross who has done a great amount of work in this direction, makes note in one of his reports of a party of boys thirteen in number, and three servants who were camping at Calcutta and slept in tents unprotected from the mosquitoes. A sister of one of the boys visited the camp, and in a short time all developed malaria. At the same

camp three officers and a friend of the officers slept in tents protected by nets and neither of these contracted malaria; thus it will be seen that of twenty-one persons, seventeen who were unprotected and exposed to the stick of the mosquitoes developed malaria, while four who were protected from the bite of the mosquitoes escaped infection. Ross has mentioned many such instances as the above.

W. F. Arnold's report of malaria in the North Atlantic Squadron in Cuba during the Spanish-American war, refers to lowlands and mosquitoes as the cause of malaria, and also refers to the dissemination of the malady by water in rare cases in some localities. Among other outbreaks of malaria mentioned in his report the following might be considered as most important: three gunboats, the Vixen, Scorpion, and Manning of the squadron outside of Daiquiri while cruising near the shore and anchoring at the pier developed many cases of malaria among the sailors on board; in searching for the cause he found that 187 men of the Scorpion and Vixen used water piped from the hills into an open and bird-befouled tank. Thirty-eight cases of the worst form of malaria developed; these latter cases seemed to suggest that the disease is water born; he did not however take note of the fact that these men were exposed and actually bitten by mosquitoes, until 23 cases of malaria developed on the Manning which did not anchor at the dock, but three hundred meters distant; however he noted the fact that the men on the Manning did not get water from the same source as the sailors on the Vixen and Scorpion but that the former were supplied with distilled water. He accounted for the 23 cases on the Manning by the fact that the mosquitoes abounded on the shore and a good land breeze was continually blowing, carrying the mosquitoes to the ship which was only at a distance of one thousand feet from shore. The sailors and marines of the large ships which were at a farther distance from shore did not develop a single case of malaria, and the Saint Louis had many malarial patients on board, they having contracted the disease while on land; many of them were of Admiral Cervera's fleet. To again demonstrate the distinct rôle of a certain species of mosquito as the cause of malaria the following is quoted from Arnold's report:

"Six hundred marines unacclimatized dig intrenchments under fire, sleep in their soiled clothing in new earth-works and in tents without flooring for at least two weeks, they maintain outposts in and near salt marshes beset with mosquitoes and acquire little or no malaria, while nearly an army corps is incapacitated by malaria only forty miles distant; the report does not state environments of this army corps, as regards marshes and mosquitoes."

If the foregoing explanation is not sufficient evidence to convince many of the causal relation which the mosquito bears to malaria the experimental proof of the mosquito-malaria theory as reported by Dr. Manson of the London School of Tropical Medicine ought to remove all doubt from the minds of the profession and laity as regards this theory.

In January, 1900, Manson in an article in the *British Medical Journal* reported that a series of experiments would be made. One in the Roman Campagna and another in London under his personal direction with eggs of mosquitoes hatched in lot and fed on blood of malarial patients and shipped to London. He prophesied in detail the outcome of the experiment which will be more fully described under the report after the experiment.

We will conclude this short article by a brief resumé of Dr. Manson's experiments which were conducted in the Roman Campagna and in London. The London experiment was conducted by Dr. Manson, after receiving relays of mosquitoes infected with the benign variety of tertian malaria, as the malignant tertian parasite might have endangered the life of the subject of the experiment, and the quartan, though not specially dangerous to life, is difficult to eradicate. It was through the great care exercised by Bignami and Bastianelli that only pure benign infected insects were sent to Dr. Manson. Hundreds of mosquitoes were sent to London but only half a dozen survived the journey. Dr. Manson's son, Mr. Thurbur Manson, was the subject of the experiment. He had never lived in a malarious region, and never had had an attack of malaria, nor did his blood after repeated examinations show any parasites.

It was only after the third consignment of mosquitoes were re-

ceived and allowed to feed on his arm, that he developed any symptoms and his blood showed any parasites. After the presence of the parasite was verified by several other professional and laymen who saw the experiment carried on from its very beginning and also saw the blood films prepared; several ten-grain doses of quinine were taken with a subsidence of all symptoms and a disappearance of the parasites from the blood.

The experiment in the Roman Campagna was carried out by Drs. Sambon and Low, and Signor Terzi and two Italian servants under instructions from Dr. Manson. It is a well-known fact that travelers coming to Rome during the summer almost invariably develop malaria (Roman fever as it is commonly known). They entered a hut which was constructed in England, the doors and windows having been protected by proper screens, after selecting one of the most intensely malarious districts and the season during which malaria is at its height. Neither of them took a grain of quinine, going about during the day unprotected, the only precautions taken were to remain in the hut from sunset to sunrise, and always, of course, with an eye on *Anopheles*; by way of extra precaution, mosquito nets were placed around their beds. Up to September 21, the last report published by the experimenters, they enjoyed perfect health, in marked contrast to their neighbors who were all either ill with fever or had suffered with malarial attacks. From a careful study of these experiments it seems probable that protection from the mosquito bites protects from malaria.

It will be noticed from these last experiments that the *Anopheles* is the only species mentioned, the *Culex* being entirely lost sight of. In the experiments of Grassi and others also made in the Roman Campagna the *Anopheles* was the only mosquito used for infecting man; in Grassi's report of his experiments he states that the subjects of his experiments were always exposed to the *Culex*, none of them developing the disease.

Firmi and Towsini on prophylaxis of malaria by destruction of mosquito, report result of their experiment to stamp out malaria on the convict island of Asinara on which there were eleven malarious

localities, sixty-seven cases were of severe type of the fever, three methods were employed.

1st. The surface of all ponds and lakes was covered with petroleum, and the cleansing thoroughly all drinking tanks, thus destroying eggs and larvæ.

2nd. Destruction of adult mosquitoes by mixture of powders, or chlorine gas.

3rd. Excluding mosquitoes from dormitories by proper means.

As a result of these measures during a period of nine months in the malarial season no cases occurred on the island; the nine cases in the hospital having been infected prior to the experiment or at some other locality.

PERICARDITIS COMPLICATING TONSILLITIS: REPORT OF A CASE.

BY DR. A. A. SHAWKEY, '00.

Numerous observations have recently been made regarding the relation between tonsillar affections, in their various forms, and rheumatism, with the result that various theories have been advanced, some attributing to tonsillar affections an etiological relation to rheumatism, while others hold that the rheumatic diathesis is a factor in the causation of tonsillitis. Personally I have not given the subject sufficient attention to justify an advocacy of any theory, but desire to present the following brief report, believing that it will be of interest both because of its bearing upon the above mentioned relation and because of its comparative rarity:

Mr. O. E. D. Age thirty years. Single. An assistant in the office of the State Treasurer. Subject to no exposure. Never had rheumatism previous to the date of this illness. Has had several mild attacks of catarrhal tonsillitis.

Patient called at my office between seven and eight P. M., August 14, 1900, complaining of slight lumbago which had troubled him for five or six days, and sore throat which had begun that morning and gradually grown worse. Examination revealed a beautiful case of acute parenchymatous tonsillitis.

I prescribed calomel in divided doses, and a 50 per cent solution of hydrogen peroxide as a gargle.

At half past three the next morning I was called to see the patient and found him suffering agonizing precordial pain, which had begun about nine o'clock the evening before and gradually increased. Careful examination resulted in the diagnosis of acute plastic pericarditis, regardless of the fact that such intense pain is the exception in this affection. The auscultatory signs were distinctive, including the *bruit de cuir neuf* or new-leather murmur of the French.

The patient objected to the use of morphine either hypodermically or otherwise, preferring to endure the pain for a time; so I prescribed salicylate of soda in 15-grain doses, repeated in half an hour, again in an hour, and then at longer intervals, and ordered an ice bag over the heart.

I stayed with the patient for an hour, when he was sufficiently relieved to sleep for two hours, waking with but slight pain about the heart.

The patient passed the day quite comfortably and by the morning of the 16th there were but very slight traces of soreness about the pericardium, but the left tonsil showed signs of beginning abscess. The use of the bistoury was followed by the evacuation of a small amount of pus, and the usual relief from congestion and pain.

The patient was very weak but convalesced with unexpected rapidity and in a few days was at his desk again with no reminders of his illness except a slight recurrence of the lumbar pains, which required only the administration of a few more doses of salicylates.

Observation and the result of therapeutic tests confirmed, in a satisfactory manner, the diagnosis; and while the case may not provide proof positive of any theory, still, to my mind, it presents a pleasant picture, which is doubly interesting because of its bearing upon the relation apparently existing between the diseases mentioned.

REMOVAL OF A FOREIGN BODY FROM THE BLADDER.

(SERVICE OF DR. H. H. HAYDEN.)

BY DR. J. A. PENTON, '00.

J. B., white, single, printer by occupation, entered hospital on June 14, 1900. Patient complained of pain in the region of the bladder and in the penis; also disuria. He said that on the night before he had introduced a wire into his urethra, and the room being dark in which he was at the time, it got beyond his reach. He stated that he had introduced the wire because he could not pass his water. Patient seemed to be an individual of dubious morale. Among other statements bearing on the subject, he said that he had never indulged in sexual congress. On examination, a small puncture was seen, which was located about one-eighth of an inch from the meatus. Careful search of the membranous portion of the urethra did not reveal the presence of the wire, but a sound introduced into the bladder clearly demonstrated the presence of the foreign body. There was no hæmaturia or retention of urine after his admission to hospital. A microscopical examination of a purulent discharge from the urethra revealed the presence of gonococci. On the following day Dr. Hayden performed a superpubic cystotomy. A small, flexible double-twisted wire about six inches long, to one end of which was attached several loops of horse hair, was removed—the instrument better known by poultrymen as a “chicken gaper.” Patient is now convalescent.

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THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

THE VIRGINIA STATE BOARD STATISTICS

Through the courtesy of Dr. R. Sumpter Griffith, of Basic City, Va., we have received a clipping from the Richmond Journal of Practice for Sept., 1900, giving a synopsis of fifteen years' work of the medical examining board of Virginia.

The following table presents the percentage of rejections from the various schools by states. While this form of tabulation does not give the fairest results to individual schools it answers the present purpose.

Virginia	9%	Vermont	60%
New York	20	Missouri.....	66
Michigan	22	Georgia	70
Kentucky.....	23	District of Columbia.....	79
Maryland.....	30	Tenn.....	80
South Carolina.....	33	Harvard	100
Pennsylvania	38	Non-Graduates	60
Ohio	50		

The editor goes on to say: "Taken at its best the result is a most stinging criticism of the way medical schools have been conducted in the past."

But we would like to ask is the inefficiency of the medical schools of the country the only explanation for the amazing disparity in the apparent qualification of the graduates in medicine? We will say

nothing of the Maryland schools, they stand better than the average but that is bad enough.

To judge from the figures the University of Harvard is totally incompetent to educate a student of medicine. Does any sane person believe the implication? Does any sane person believe that the schools of Virginia are more than twice as competent to impart necessary knowledge to the medical student, as the schools of New York? more than four times as competent as the schools of Pennsylvania? more than five times as competent as the schools of Ohio? or nearly nine times as competent as the schools of the District of Columbia? Is it reasonable to presume that the graduates of half of the schools of the country are less competent to practice medicine than men who have not graduated at all?

The table implies that all of these questions should be answered in the affirmative. We do not believe that there is a man living who has any knowledge of the subject who would not answer each question with a resounding negative.

We can think of only two explanations of these extraordinary statistics.

One is that the field offered for practice in Virginia is so poor that only the less ambitious and least competent graduates from the great schools of the country select that state for a location. This is not complimentary to the state and we do not believe it is true.

The only other explanation is that the board has been affected by influences favorable to the graduates from the state institutions. This is not complimentary to the board, but it is certainly impossible to avoid the inference from their own statistics.

There is no question that the schools of Virginia do excellent work, but when the board statistics show that only nine per cent of their graduates fail to pass the state board when thirty-eight per cent of the graduates of the schools from Pennsylvania fail to pass, it is very clear that the difference is not in the methods of teaching but must be either in the applicants or in their method of treatment by the board.

We heartily agree with the editor of *Practice* when he says: "It

is to be hoped that with the advent of the new century the Virginia board will close its books and begin a new and better record."

Personal Notes.

DR. J. FRANK RUTHERFORD, '92, has returned from New Mexico to his old location at Bishop, Pa.

DR. W. F. TURLINGTON, '94, was married October 24, 1900, at Fremont, N. C., to Miss Neta Mayfield Yelverton.

DR. D. M. MILLER, '87, Indian Springs, Tenn., is President of the East Tennessee Medical Society. At the election in November Dr. Miller was elected a member of the Legislature of Tenn.

DR. ISAAC J. MARTIN died suddenly at Ellicott City, Md., Nov. 16, '99. Dr. Martin never engaged in practice but devoted his time to the pharmacy which he and his brother, Mr. R. Abbey Martin, inherited from their father.

DR. SAMUEL W. LINCOLN, '79, was thrown from his carriage by a runaway horse at Moline, Ill., Feby. 2, 1900. He received such severe injury to his brain that he never regained consciousness and died Feby. 7.

Dr. Lincoln was born in Plainfield, Mass., and practiced in Nelson, Penn., until 1887. He then removed to Ill., where he practiced until his death. He enjoyed a large practice and was very successful.

DR. S. WALTER WOODYARD, '91, of Greenville, Tenn., sends in the following notes of his classmates:

Dr. J. O. McReynolds, Jr., is located in Dallas, Texas, where he has made a splendid record as a surgeon. Dr. McReynolds carried off "first honors" at the commencement, also the "Anatomical Prize." He is a member of the Texas Medical Society and of the American Medical Association.

Dr. Wm. J. Hunt is enjoying a lucrative practice at Glen's Falls, N. Y., and is a member of the American Medical Association.

Dr. W. E. Fitch is enjoying a lucrative practice in Savannah, Ga. He is a member of several societies, a gifted writer and the editor of the Georgia Journal of Medicine and Surgery.

Dr. J. Percy Wade succeeded Dr. Rohé as Supt. of the Maryland Hospital for the Insane at Catonsville, and is an honor to the profession. Dr. Wade is a member of his State and local societies and the A. M. A.

Dr. Sam'l E. Hughes has an excellent practice in Danville, Virginia, and is a member of the Medical Society of Virginia.

Dr. W. S. Gilroy is located in Baltimore and enjoys an extensive practice. Dr. Gilroy was Vice-Pres't of the class.

Dr. Chas. E. Greene is with a large chemical house of New York.

Dr. W. L. Champion is practicing in Atlanta, Ga. He is making genito-urinary diseases a specialty and is a frequent contributor to medical literature. He is a member of the A. M. A.

Dr. Harvey P. Jack is located at Canisteo, N. Y. He is a frequent contributor to the journals and holds several positions of trust. Dr. Jack took a special course in the Johns Hopkins Medical School during the summer of '98.

Dr. O. L. Perry is doing a large practice at Junior, West Virginia. He is President of the Board of Health, examiner for several large life insurance companies and physician to the Junior Coal Co.

Dr. Everett Reeves is located at Lamar, N. C., where he has an extensive general practice. He is a member of the North Carolina Medical Society and the Ashe County Medical Society. Dr. Reeves was a member of the General Assembly of N. C. from 1898 to 1900. He was married on June 12, 1900, to Miss Pauline Welborn, of Wilkesboro, N. C.

Dr. George R. Glass is in partnership with his brother at South Fork, Penn., and has succeeded well. Dr. Glass' individual work is principally confined to surgery and he has done some successful oper-

ating. He has been surgeon to the Penn. R. R. for the past eight years.

Dr. J. J. Goff is doing a large practice at Sistersville, West Va., and is a member of the American Medical Association.

Dr. Louis F. High is practicing in Danville, Virginia and is doing well. He has made a special study of tuberculosis and has contributed to medical literature, several papers on the management and treatment of pulmonary troubles. During the autumn of 1900 he spent several weeks in New York doing post-graduate work. He is a member of his State society and also the American Medical Association.

ALUMNI IN TEXAS.

After diligent inquiry I have been enabled to locate some few (over thirty) of "the boys" in Texas.

Frank Hall, '97, Jno. O. McReynolds, '91, and Scurry Terrell, '95, are all in Dallas. Drs. Hall and McReynolds doing eye, ear, nose, and throat work, and Scurry doing general practice.

In Ft. Worth we find Jimmie Cooper, '83, Billie Thompson, '88, and Bev. West, '85. Jimmie is doing general practice, Dr. Thompson, eye, ear, nose and throat work, and Dr. West, genito-urinary, rectal and skin.

In Corsicana we find Clay Johnson, '91, T. R. Turner, '81, and J. M. V. Wells, '81.

Dr. Varney Andrews, '90, represents us at Valley View, and Adoniram Farrell, '83, at Wharton.

Dr. B. T. Bell, '81, can be found at White House, and Dr. W. A. Winn, '91, at Granger.

At Kaufman we can readily locate Manning Grigsby, '93. Dr. Grigsby when a boy lived in this county and was then known as "Whistling Jake."

Dr. Ben Beeler, '95, and Dr. Yeager, '84, are at Mineral Wells, and Dr. Walt. Mathews, '93, and Dr. J. M. Wallse, '96, at Naples.

If we enquire at Saltillo we will find Dr. W. H. Arthur, '88, and at Rheas Mills, Dr. Jas. Greer, '91.

Dr. Geo. McHenry, '82, is at San Angelo, Dr. Billie Whittle, '82, at San Antonio, Dr. Chuse, '96, at Shafter, Dr. Person, '85, at Snyder, Dr. Barnes, '96, at Trinity, and Dr. Caleb Smith, '87, at Tyler.

Waco caught Dr. Phil Hengst, '83, Agnes, Dr. Jno. Moore, '80, Brandon, Dr. Jim Spaulding, '84, Carthage, Dr. Chas. Corner, '86, and Elgin Dr. Dennis Atkinson, '80. This is all that I have found in Texas.

In a future letter I will tell you of those I know who are located outside of Texas.

Yours fraternally,

U. E. G. DYER, '92, Star, Texas.

FALL RIVER, MASS.

DR. WM. J. TODD.

Dear Doctor:—Having lately returned from abroad after an absence of a few years in the hospitals of Paris, I desire to inform you that I have just received my first copy of the JOURNAL since I went away. I have not received any bill from you, but enclosed you will find one dollar, and if you can I would like to receive the back numbers for the year. It is surprising to hear some graduates kick about one dollar for their JOURNAL, when the same fellow will not mind throwing away fifty times more than the cost of his JOURNAL on some foolishness or other. Just the last number was worth more to me than ten times the cost just to hear that my friend John C. Morfit, '95, was getting along fine and I am very glad to hear it and I would be real glad to hear from more of my class-mates. I would like to know what can please a young physician more than to hear of a fellow class-mate in another part of the country getting along well. There are in this city six or seven P. & S. men and every one of them is doing well. As for myself, I have opened an office here and have taken up the eye, ear, nose and throat only, and I am very well satisfied so far.

While abroad I was in the service of Profs. Panas and Landolt on the eye, and Profs. Lermoyer and Castex on the ear, nose and throat, and found them kind and obliging to all Americans who visited them.

With best regards to my friend, Dr. Chas. E. Brack, etc., and

wishing luck and prosperity to the JOURNAL OF THE ALUMNI ASSOCIATION,

I remain respect. yours,

A. ST. GEORGE, '95.

Baltimore, Oct. 25, 1900.

The College Medical Society was reorganized Oct. 24, 8.30 P. M., under favorable conditions. The attendance was large, and much enthusiasm prevailed. The following officers were elected for the ensuing year: President, J. M. Barry; Vice-President, A. L. Kee; Secretary, Tunis Nunemaker. The following constitute the Executive Committee: Prof. George J. Preston, representing the Faculty; Dr. C. W. G. Rohrer, the House Staff; Chas. H. Brueckner, S. T. Lowry, and W. S. Partridge the Class of 1901. The Society has a bright future before it.

C. W. G. ROHRER, Chairman of Executive Com.

KANSAS CITY, Mo.

J. C. MORFIT, M. D., Mo. State Chairman Alumni Association, College P. & S. of Baltimore.

Dear Dr.—It gives me great pleasure to hear from an alumnus of our dear old P. & S. I have received several copies of the ALUMNI JOURNAL, which gives me great pleasure to read, notwithstanding I seldom see mention of any of my old class of '88. I pitched my tent in this city in April, '88, directly after graduating, possibly it was a force of circumstances that I remained here, as, when I struck this place I had to stay on account of depleted finances, so I went to work and have been working ever since. I presume I have not accomplished as much as many of the other boys, but nevertheless I suppose I had better not grumble.

In 1893 I was one of the promoters of the college of P. & S., medical department of the K. C. University, of which I was made secretary, and still hold the office. I hold the chair of Obstetrics and assistant to the chair of Gynecology. I have the honor of being a member of the British Medical Association, also Obstetrician to Bethany Hospital, and consulting Obstetrician to the Hospital for Women and Children.

It is too bad that we have lost such a valuable man and one so well beloved by our Alumni, as Dr. Rohé. I met him in Montreal two years ago when attending the British Medical Association, he was quite prominent in some of the sectional discussions. Dr. J. E. Sawtell class of '86 is located here and Dr. Z. Nason, class of '88 is located across the border in K. C., K., both of whom hold chairs in the P. & S.

Doctor, I wish to extend to you, or any of our Alumni an invitation to make my home headquarters when visiting our city.

With best wishes to you, to the Alumni Association, our Alma Mater, and prosperity to the ALUMNI JOURNAL. I remain,

Yours fraternally,

E. M. HETHERINGTON, M. D.

P. S.—Enclosed you will find \$1 subscription.

MONETT, Mo.

Dear Doctor.—I am in receipt of your favor of the 9th inst. kindly informing me that we are Alumni of the same Alma Mater and of the number of us in our State, and that you are seeking a full report of the Mo. boys, which I am sure I will appreciate, for I have not had the pleasure of meeting with any of our boys for several years. I have received a sample copy of the JOURNAL which I have read with interest, for I am always anxious to hear anything from the old College.

I am a graduate of the class of 1879. I practiced for three years at my home at Rossville, Ga., came to Cassville, Mo., in 1882 and remained there until 1893, since '93 have been in Monett, Mo. Have had a good practice in this State. I am a member of the American Med. Association, The Southwest Mo. Dis. Society and International Association of Railway Surgeons. I am Local Surgeon for the St. L. and S. F. R. R. Co. and Examiner for a number of insurance companies. I am married and have a very pleasant family and home.

Enclosed please find \$1 for the JOURNAL OF THE ASSOCIATION.

I thank you for the kind invitation that you extend to me, and hope it may be my good fortune to meet you and to become better acquainted.

Very truly yours,

A. S. HAWKINS, '79.

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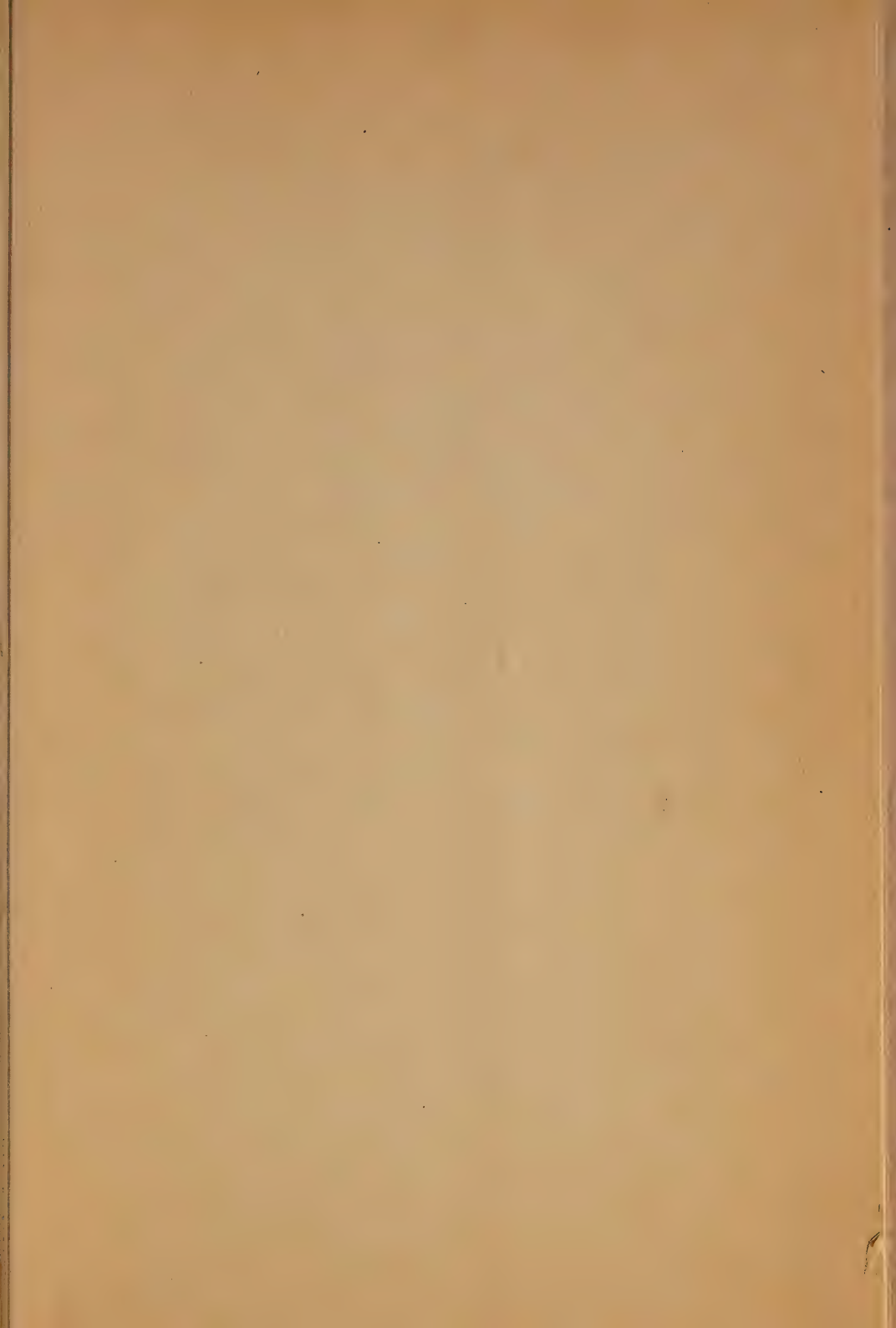
The Sixty-First Annual Session will commence on the 1st of October, 1900, and continue until May, 1901.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD



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- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- SYLVAN ROSENHEIM, M. D.,
Demonstrator of Bacteriology.
- ARCHIBALD C. HARRISON, M. D.,
Assistant Demonstrator of Anatomy.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. SAMUELS, M. D.,
Clinical Assistant in Gynecology.
- W. B. WOLF, M. D.,
Demonstrator in Clinical Laboratory.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- S. S. HOULTON, M. D.,
Assistant in Diseases of Stomach.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1898, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternity Hospital, Bay View Hospital.

For further information, address

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